Supreme Court, U.S.
FILED
06-474 SEP 29 2006
OFFICE OF THE CLERK

No. _____

In the Supreme Court of the United States

BRUCE GOLDBERG, in his official capacity as Director, Oregon Department of Human Services, et al,

Petitioners,

v.

WILLIAM W. WATSON, JR., et al,

Respondents.

Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Faced with a severe budget crisis, in 2003 the Oregon Department of Human Services, with the approval of the federal agency that administers Medicaid, cut some of the service levels used to determine who is eligible for services offered under the state's home and community based services program, which is an optional Medicaid program, and for nursing home services. Plaintiffs were affected by those cuts, and they brought suit under 42 U.S.C. § 1983 against the Director of the department and two of the department's assistant directors. Although both the district court and the court of appeals purported to apply this Court's analysis in *Gonzaga Univ. v. Doe,* 536 F.3d 273 (2002), at least as to the one Medicaid provision that still is at issue in this case, the district court and the circuit court reached different conclusions about whether Congress intended to create private rights enforceable under § 1983. The district court held that none of the Medicaid provisions cited by the plaintiffs created rights enforceable under § 1983. The court of appeals, considering two of plaintiffs' statutory claims, held that one provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(10), created rights enforceable under § 1983, but that another provision of the Act, 42 U.S.C. § 1396a(a)(17), did not. This case presents the following questions:

1. Section 1396a(a)(10) of the Medicaid Act provides that a state plan for medical assistance must provide for making available certain medical assistance, including nursing home services. Does that provision of the Act create private rights that are enforceable in a § 1983 action? More broadly, what is the correct analysis that should be employed when determining whether federal statutes, enacted under the Spending Clause, create individual rights that can be enforced under § 1983?

2. When Congress has provided an enforcement mechanism in a statute that is different from, and more restrictive than, § 1983, does that fact signal that Congress did not intend to create a private right of action?

PARTIES TO THE PROCEEDING

Petitioners are Bruce Goldberg, M.D., the Director of Oregon's Department of Human Services (DHS), James Toews, Assistant DHS Director, Seniors and People with Disabilities Division, and Allen Douma, M.D., Assistant DHS Director, Division of Medical Assistance Programs.

Respondents are individuals who were affected by the State's elimination of eligibility to those in certain service priority levels and the Oregon Advocacy Center.

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I. In spite of this Court's efforts in *Gonzaga* to "resolve any ambiguity" in its opinions, the courts of appeals admittedly still struggle when interpreting and applying that case law. 18

II. Lower courts misread and misapply *Gonzaga*, and sometimes appear to ignore aspects of that decision; for those reasons, the decisions of lower courts are not faithful to *Gonzaga* and are inconsistent with each other. 19

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PETITION FOR CERTIORARI

Petitioners, the Director of the State's Department of Human Services and two of the department's assistant directors, respectfully pray that the Court issue a writ of certiorari to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit in *Watson v. Weeks*, 436 F.3d 1152 (9th Cir. 2006).

OPINIONS BELOW

The magistrate judge's findings and recommendation is not reported and is attached to this petition. App. 1-26. The district court's order adopting the findings and recommendation is not reported and is attached. App. 27-34. The Ninth Circuit Court of Appeals decision is reported at 436 F.3d 1152 (9th Cir. 2006), and also is attached to this petition. App. 35-55. The state petitioners sought panel rehearing or rehearing *en banc*, and the Ninth Circuit's denial is attached to this petition at App. 56.

JURISDICTION

The opinion of the Ninth Circuit Court of Appeals was filed on February 8, 2006. The order of the court of appeals denying the petition for rehearing and suggestion for rehearing *en banc* was filed on June 1, 2006. This petition is timely filed within the additional time allowed by Justice Kennedy on August 22, 2006. This Court's jurisdiction is invoked under U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

This case involves provisions of the Medicaid Act, 42 U.S.C. § 1396 *et seq*, and, more specifically, of section 1396a of the Act. The pertinent statutory provisions are set forth at App. 57-63.

STATEMENT

The central issue in this case is whether provisions of the Medicaid Act and, in particular, 42 U.S.C. § 1396a(a)(10) – the provision relied on by the Ninth Circuit – create private rights of action enforceable under 42 U.S.C. § 1983. The Ninth Circuit held that section 1396a(a)(10) created such individual rights, but that another provision of the Act, 42 U.S.C. 1396a(a)(17), did not. *Watson*, 436 F.3d at 1159-63.

I. The Medicaid Act

"Medicaid is a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals. 42 U.S.C. § 1396 (1982 ed., Supp. V)." *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990). Although participation in Medicaid is voluntary, "participating States must comply with certain requirements imposed by the Medicaid Act (Act) and regulations promulgated by the Secretary of Health and Human Services (Secretary)." *Id.* Oregon participates in Medicaid.

The Act requires a State to submit a "State Plan" for approval by the Secretary. 42 U.S.C. § 1396; 42 C.F.R. § 430.10. Under the program, a State must pay for certain services and may elect to pay for additional services. 42 U.S.C. § 1396a(a)(10)(A), (C); 42 C.F.R. §§ 440.210, 440.220.

Plaintiffs have alleged that participating States must pay for at least seven categories of medical services to persons deemed to be eligible Medicaid recipients. 42 U.S.C. § 1396a(a)(10)(A). One of the seven categories of mandatory services is nursing facility services. 42 U.S.C. § 1396a(a)(4)(A). The Act also allows States, at their option, to provide home and community-based services as an alternative to nursing facility services. 42 U.S.C. § 1396a(a)(10)(A)(ii)(VI).

Under the Act, States may request waivers of certain federal Medicaid requirements in order to develop community-based treatment alternatives to institutional care that would otherwise be covered by Medicaid. Waivers "permit a State to implement innovative programs or activities on a time-limited basis, and subject to specific safeguards for the protection of recipients and the program." 42 C.F.R. § 430.25(b). A waiver "under section 1915(c) of the Act allows a State to include as 'medical assistance' under its [Medicaid state] plan home and community-based services [HCBS] furnished to recipients who would otherwise need inpatient care that is furnished in a hospital, SNF [skilled nursing facility], ICF [intermediate care facility], or ICR/MR [intermediate care facility/mental retardation] and is reimbursable under the State plan." 42 C.F.R. § 430.25(c)(2). The Secretary will "approve waiver requests if the state's proposed program or activity meets the requirements of the Act" and certain specified regulations. 42 C.F.R. § 430.25(g)(1).

An initial waiver for home and community-based services under section 1915(c) is for a period of three years and subsequent renewals are for five year intervals. 42 C.F.R. § 441.355 (2). States have the flexibility to design each waiver program and select the mix of waiver services that best meets the needs of the population they wish to serve. *Id.*

The State is required to specify in the waiver application the number of recipients to be served under the HCBS waiver program. 42 C.F.R. § 441.303(f)(6). This number "will constitute a limit on the size of the waiver program unless the State requests and the Secretary approves a greater number of waiver participants in a waiver amendment." *Id.* Once approved, a State can submit an amendment to its HCBS waiver at any time to change the services provided, to change the population served by the waiver, to change the qualifications of providers, service area of the waiver, statutory sections

waived, or to make other changes to the waiver program, subject to approval by the federal Centers for Medicare and Medicaid Services (CMS). 42 C.F.R. § 441.355.

The Secretary is required to "monitor the implementation of waivers granted under this section to assure that the requirements for such waiver are being met and shall, after notice and opportunity for a hearing, terminate any such waiver where he finds noncompliance has occurred." 42 U.S.C. § 1396n(f)(1). If a State offers services not approved by CMS under its waiver, the State will be required to return the federal share – the federal financial participation or FFP – paid for any such services.

A waiver program is subject to termination by CMS. If CMS finds, during an approved waiver period, that an agency is not meeting one or more of the federal requirements for a waiver under Title XIX and regulations, CMS notifies the agency in writing of its findings and grants an opportunity for a hearing in accordance with 42 C.F.R. § 441.357. 42 C.F.R. § 441.356(b).

A State can voluntarily terminate a home and community-based services waiver program at any time before the expiration of the waiver period by notifying CMS in writing 30 days before terminating services to recipients, and by notifying recipients at least 30 days before terminating services in accordance with 42 C.F.R. § 431.210. 42 C.F.R. § 441.356(a).

II. Oregon's HCBS Waiver Program

Oregon has elected to operate a waiver program for aged and physically disabled individuals, approved since 1981.[1]

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[1] Under Oregon's HCBS waiver for aged and physically disabled, individuals under 65 whose primary diagnosis is developmental disability or mental illness are not eligible for waiver services. Or. Admin. R. §411-015-0015(4)(c).

Medicaid law covers long term care of eligible elderly and disabled individuals only if the care is provided in a nursing home or institution. Medicaid law does not require states to offer in-home or community-based services to the elderly and disabled, and such community-based services are not covered by Medicaid, absent a waiver.

In order to provide such optional Medicaid services, a State has to apply to CMS for a waiver. In 1981, DHS applied for an HCBS waiver to allow Oregon to provide in-home and community-based services to elderly and physically disabled individuals who would otherwise require institutionalization in a nursing facility. The waiver application was approved by CMS.[2]

Oregon applies the same standards to determine eligibility for nursing facility and HCBS waiver services. Those standards are defined by "service priority levels" that rate the need for services. Oregon's standards for eligibility for nursing facility and HCBS waiver services — including service priority levels 1 through 17, as defined in Or. Admin. R. § 411-015-0010, and the Client Assessment and Planning System (CA/PS), which determines an individual's service priority level from 1 through 17 — were approved by CMS as part of the waiver program. CMS approved renewal of Oregon's HCBS waiver program for another 5-year period, effective October 1, 2001.

The State had been providing services to financially eligible individuals in service priority levels 1 through 17 (where level 1 includes those who need the most assistance and level 17 includes those who need the least, Or. Admin. R. § 411-

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[2] Oregon's HCBS waiver was later renewed from October 1, 2001 through September 30, 2006. Current renewal is pending.

015-0010). Due to a severe state government budget crisis, in 2003 DHS reduced the population served by nursing facilities and the HCBS waiver program. On January 27, 2003, DHS submitted an amendment to the waiver to eliminate levels 15 through 17 from the State's nursing facility levels of care served by the waiver program, effective February 1, 2003. The amendment states that this would reduce the HCBS waiver population by approximately 4000 individuals receiving in-home and community-based services, and approximately 85 individuals receiving services in nursing facilities. Administrative rules were revised to reflect the change, and notice was sent to individuals in service priority levels 15 through 17 regarding termination from service, their right to request a reassessment of their service priority level, and their hearing rights.

On February 24, 2003, DHS submitted an amendment to CMS to eliminate levels 10 through 14 from the State's nursing facility levels of care, effective April 1, 2003. The amendment states that this change would result in a reduction of approximately 6100 individuals from in-home and community-based waiver services, and approximately 300 individuals from nursing facilities. The revised number of individuals to be served will be a new limit or cap on the waiver population. Administrative rules were revised to reflect the change, and notice was sent to individuals in service priority levels 10 through 14 regarding termination from service, their right to request a reassessment of their service priority level, and their right to a hearing.

The Oregon legislature later restored funding for levels 10 through 11 through June 30, 2003. On March 31, 2003, DHS filed an amendment to the waiver with CMS to reflect this

change. Administrative rules were adopted to reflect this change.[3]

Approval by CMS constituted the only federal action needed to reduce the population served by Oregon's HCBS waiver program. CMS approved the request to amend Oregon's HCBS waiver program for long-term care for the aged and disabled to eliminate individuals in levels 12 through 17 from the population served by the waiver.

These DHS actions of obtaining CMS approval of the amendments to the HCBS waiver, and adopting administrative rules to implement the changes, terminated DHS authority to include certain service priority levels as part of its HCBS waiver program. The termination of certain service priority levels from the HCBS waiver program means that DHS cannot claim any federal financial participation for its expenditures for any waiver services to these individuals. They are no longer included in Oregon's HCBS waiver population.

If Oregon had been unable to reduce the population served by the HCBS waiver program due to lack of funds, Oregon might have needed to terminate the HCBS waiver program entirely. Under Title XIX, Oregon can terminate the HCBS waiver program at any time, pursuant to 42 C.F.R. § 441.356, upon 30 days written notice to CMS and to recipients of waiver services.

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[3] The rules later were amended again to restore services to levels 12 and 13. Or. Admin. R. § 411-015-0015(1). On October 31, 2003, DHS filed a waiver amendment with CMS to reflect the legislatively-restored funding for levels 12 and 13. As of the date of the filing of this petition, the State continues to provide services to those in levels 1 through 13. Or. Admin. R. § 411-015-0015(1) (2006).

III. Litigation in the District Court

Plaintiffs brought this action against the state defendants under § 1983, alleging that the termination of services to those in certain service levels violated their rights under provisions of the Medicaid Act. Other claims are no longer part of this litigation but, as pertinent here, plaintiffs contended that ceasing to provide services to those in some service levels violated 42 U.S.C. § 1396a(a)(10), and plaintiffs claimed that provision created a private right of action enforceable under § 1983. The magistrate judge rejected that contention, concluding that the pertinent provision "does not include the kind of 'right-creating' language" that is required, and that instead "it addresses 'aggregate' rights as opposed to individual rights, and focuses on what a state must do to be eligible for federal funding." App. 15.

> Though the terms of th[e] section may indicate that plaintiffs are within the "general zone of interest that the statute is intended to protect," they fall short of describing the kind of "unambiguously conferred right" necessary to render the statute actionable under § 1983. Section 1396 [of the Medicaid Act] addresses what a state must do to qualify for federal funding. A state's failure to meet those requirements logically results in a loss of funding, not the creation of individual rights of recipients to continue to receive benefits.

App. 15, quoting *Gonzaga Univ. v. Doe,* 536 U.S. 273, 282-83 (2002). The magistrate judge recommended that the state defendants' motion to dismiss and for summary judgment (on another claim) should be granted, and that the plaintiffs' cross-motion for summary judgment should be denied. App. 25-26.

Plaintiffs filed objections to the magistrate judge's findings and recommendation, and the matter was referred to a district court judge. Ultimately,[4] the district court judge "adopt[ed] the Findings and Recommendation as well-reasoned and correct. The provisions of the Medicaid Act at issue in this action do not contain rights-creating language unequivocally conferring an individual right to support a cause of action under § 1983." App. 31. The district court granted the state defendant's motion to dismiss plaintiffs' claims (and granted summary judgment as to a claim that is not at issue here). The court denied plaintiffs' motion for summary judgment. App. 34. Plaintiffs' § 1983 claims were dismissed with prejudice. App. 34.

IV. Appeal to the Ninth Circuit Court of Appeals

Plaintiffs appealed to the Ninth Circuit Court of Appeals. Among other claims, they contended that the district court had erred in determining that they did not have a private right of action under two provisions of the Medicaid Act, 42 U.S.C § 1396a(a)(10) and 42 U.S.C. § 1396a(a)(17). The court of appeals held that plaintiffs have a private right of action under 42 U.S.C. § 1396a(a)(10), but not under 42 U.S.C. § 1396a(a)(17). *Watson*, 436 F.3d at 1159-63. Section 1396a(a)(17) "provides that a state plan for medical assistance 'must * * * include reasonable standards (which shall be comparable for all groups * * *) for determining eligibility for and the extent of medical assistance under this plan'"). *Watson* at 1162 (ellipses in original). Section 1396a(a)(10) provides

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[4] Plaintiffs filed an interlocutory appeal from the district court's decision not to grant a preliminary injunction. That appeal was dismissed as moot after the district court ruled on the merits. *Watson v. Thorne*, 107 Fed. Appx. 150 (9th Cir. 2004).

that "a state plan for medical assistance must provide 'for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) * * * of section 1396d(a) of this title [including nursing facility services],'" to all eligible individuals. *Id.* at 1159 (ellipses in original). The court thus held that plaintiffs do not have a private right of action under the provision requiring that a state plan must include reasonable standards for determining eligibility for medical assistance, but that they do have a private right of action under the provision outlining the types of services that must be provided to eligible individuals. The state defendants later sought panel rehearing or rehearing *en banc*, but that request was denied. App. 56.

REASONS FOR GRANTING THE PETITION

In *Gonzaga*, this Court noted that lower courts "ha[d] relied on the same set of opinions from this Court" in reaching different conclusions about the enforceability of the Family Educational Rights and Privacy Act of 1974 (FERPA). 536 U.S. at 278. That fact suggested that the Court's earlier decisions "may not be models of clarity." *Id.* The Court "therefore granted certiorari * * * to resolve the conflict among the lower courts and in the process resolve any ambiguity in our own opinions." *Id.* The Court in *Gonzaga* sought to dispel lower court confusion and conflict, and to "resolve any ambiguity," by emphatically "reject[ing] the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983," and by affirming that "it is *rights*, not the broader or vaguer 'benefits' or 'interests,' that may be enforced under the authority of" § 1983. *Id.* at 283 (emphasis in original). As will be shown below, however, despite this Court's decision in *Gonzaga*, lower court confusion and conflict continues. This Court's message in *Gonzaga* often either has not been clearly heard or has not been heeded. This Court should grant certiorari in this case in

order to clarify again the principles of law that determine when federal statutes create private rights of action enforceable under § 1983.[5]

In *Gonzaga*, the Court surveyed its case law regarding when federal statutes create individual rights that can be enforced under § 1983. The *Gonzaga* Court noted that in *Maine v. Thiboutot*, 448 U.S. 1 (1980), this Court "recognized for the first time that § 1983 actions may be brought against state actors to enforce rights created by federal statutes as well as by the Constitution." 536 U.S. at 279. "A year later, in *Pennhurst State School and Hospital v. Halderman*, * * * we rejected a claim that the Developmentally Disabled Assistance and Bill of Rights Act of 1975 conferred enforceable rights, saying:

> "In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private right of action for noncompliance but rather action by the Federal Government to terminate funds to the State."

Gonzaga, at 279-80, quoting *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 28 (1981). According to *Gonzaga*, in *Pennhurst* the Court "made clear that unless Congress 'speaks with a clear voice,' and manifests an 'unambiguous' intent to confer individual rights, federal funding provisions provide no basis for private enforcement by § 1983." *Gonzaga*, at 280, quoting *Pennhurst*, 451 U.S. at 17, 28, and n. 21.

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[5] Oregon has filed a petition seeking certiorari in another case raising this issue under provisions of the Adoption Assistance and Child Welfare Act, 42 U.S.C. §§ 620-628, 670-79a. That case is *State of Oregon v. ASW* (No. 05-1385), scheduled for the Court's conference on September 25, 2006.

"Since *Pennhurst*, only twice have we found spending legislation to give rise to enforceable rights." *Gonzaga*, at 280. In *Wright v. City of Roanoke Redevelopment and Housing Auth.*, 479 U.S. 418 (1987), this Court "allowed a § 1983 suit by tenants to recover past overcharges under a rent-ceiling provision of the Public Housing Act, on the ground that the provision unambiguously conferred 'a mandatory [benefit] focusing on the individual family and its income.'" *Gonzaga*, at 280, quoting *Wright*, 479 U.S. at 430. "[K]ey" to the Court's inquiry "was that Congress spoke in terms that 'could not be clearer,' and conferred entitlements 'sufficiently specific and definite to qualify as enforceable rights under *Pennhurst*.'" *Gonzaga*, at 280, quoting *Wright*, at 432. "Also significant" was the fact that the federal agency that administered the federal act had never provided a procedure by which tenants could complain to it about alleged failures by state agencies to comply with the federal act's rent-ceiling provision. *Gonzaga*, at 280, citing *Wright*, at 426.

The only other instance in which the Court found spending legislation to create rights enforceable under § 1983 was *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990). In that case, the Court

> allowed a § 1983 suit brought by health care providers to enforce a reimbursement provision of the Medicaid Act, on the ground that the provision, much like the rent-ceiling provision in *Wright*, explicitly conferred specific monetary entitlements upon the plaintiffs. Congress left no doubt of its intent for private enforcement, we said, because the provision required States to pay an "objective" monetary entitlement to individual health care providers, with no sufficient administrative means of en-

> forcing the requirement against States that failed to comply.

Gonzaga, at 280-81, citing *Wilder*, 496 U.S. at 522-23.

In *Gonzaga*, the Court emphasized, however, that in the Court's "more recent decisions," the Court has "rejected attempts to infer enforceable rights from Spending Clause statutes." *Id.* at 281. The Court gave as an example *Suter v. Artist M.*, 503 U.S. 347 (1992), in which the Court found no basis for a § 1983 suit brought by parents and children to enforce a provision of the Adoption Assistance and Child Welfare Act of 1980 that required States receiving funds for adoption assistance to have a "plan" to make "reasonable efforts" to keep children out of foster homes. Reading that act "in the light shed by *Pennhurst*," *id.*, at 358, the Court determined that the federal statute created no private right enforceable under § 1983.

> "Careful examination of the language * * * does not unambiguously confer an enforceable right upon the Act's beneficiaries. The term 'reasonable efforts' in this context is at least as plausibly read to impose only a rather generalized duty on the State, to be enforced not by private individuals, but by the Secretary in the manner [of reducing or eliminating payments]."

Gonzaga, at 281, quoting *Suter*, 503 U.S. at 363 (ellipses and bracketed material in *Gonzaga*). Since, in *Suter*, "the Act conferred no specific, individually enforceable rights, there was no basis for private enforcement, even by a class of the statute's principal beneficiaries." *Id.*, citing *Suter*, at 357.

The *Gonzaga* Court then turned to its decision in *Blessing v. Freestone*, 520 U.S. 329 (1997). In that case, the Court considered whether Title IV-D of the Social Security Act —

which required States receiving federal child-welfare funds to "substantially comply" with requirements designed to ensure timely payment of child support — created private rights enforceable by mothers under § 1983. The Court held that the federal statute did not create such rights, saying,

> "Far from creating an *individual* entitlement to services, the standard is simply a yardstick for the Secretary to measure the *systemwide* performance of a State's Title IV-D program. Thus, the Secretary must look to the aggregate services provided by the State, not to whether the needs of any particular person have been satisfied."

Gonzaga, at 281-82, quoting *Blessing*, 520 U.S. at 343 (original emphasis in *Blessing*).

In *Gonzaga*, the Court admitted that "[s]ome language in our opinions might be read to suggest that something less than an unambiguously conferred right is enforceable by § 1983." *Id.*, at 282. The Court gave as an example the three "factor" test taken from *Blessing*

> to guide judicial inquiry into whether or not a statute confers a right: "Congress must have intended that the provision in question benefit the plaintiff," "the plaintiff must demonstrate that the right assertedly protected by the statute is not so 'vague and amorphous' that its enforcement would strain judicial resources," and "the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms."

Gonzaga, at 282, quoting *Blessing*, at 340-41. In *Gonzaga*, the Court stressed, however, that "[i]n the same paragraph," "*Blessing* emphasizes that it is only violations of *rights*, not

laws, which give rise to § 1983 actions." *Gonzaga*, at 282-83, citing *Blessing*, at 340 (emphasis in *Gonzaga*). "This confusion," the Court observed in *Gonzaga*, "has led some courts to interpret *Blessing* as allowing plaintiffs to enforce a statute under § 1983 so long as the plaintiff falls within the general zone of interest that the statute is intended to protect; something less than what is required for a statute to create rights enforceable directly from the statute itself under an implied private right of action." *Id.*, at 283. "Fueling th[at] uncertainty [was] the notion that [the Court's] implied private right of action cases have no bearing on the standards for discerning whether a statute creates rights enforceable by § 1983." *Id.* (citations omitted).

In *Gonzaga* the Court flatly

> reject[ed] the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983. Section 1983 provides a remedy only for the deprivation of "rights, privileges, or immunities secured by the Constitution and laws" of the United States. Accordingly, it is *rights*, not the broader or vaguer "benefits" or "interests," that may be enforced under the authority of that section. This being so, we further reject the notion that our implied right of action cases are separate and distinct from our § 1983 cases. To the contrary, our implied right of action cases should guide the determination of whether a statute confers rights enforceable under § 1983.

Id. (emphasis in original). The "initial inquiry" in a § 1983 case – "determining whether a statute confers any right at all – is no different from the initial inquiry in an implied right of

action case, the express purpose of which is to determine whether or not a statute 'confers rights on a particular class of persons.'" *Id.*, at 285, quoting *California v. Sierra Club*, 451 U.S. 287, 294 (1981). "Both inquiries simply require a determination as to whether or not Congress intended to confer individual rights upon a class of beneficiaries." *Gonzaga*, at 285. "[W]here the text and structure of a statute provide no indication that Congress intends to create new individual rights, there is no basis for a private suit, whether under § 1983 or under an implied right of action." *Id.*, at 286.

Turning from a review of the Court's past decisions to the issue of whether FERPA's nondisclosure provisions created rights enforceable under § 1983, the Court determined that there was "no question" that the provisions "fail to confer enforceable rights." *Id.*, at 287.

> To begin with, the provisions entirely lack the sort of "rights-creating" language critical to showing the requisite congressional intent to create new rights. *Alexander v. Sandoval*, 532 U.S. [275,] at 288-89 [(2001)]; *Cannon* [*v. University of Chicago*, 441 U.S. 677,] at 690, n. 13 [(1979)]. Unlike the individually focused terminology of Titles VI and IX ("no person shall be subjected to discrimination"), FERPA's provisions speak only to the Secretary of Education, directing that "no funds shall be made available" to any "educational agency or institution" which has a prohibited "policy or practice." 20 U.S.C. § 1232g(b)(1).

Id. "FERPA's nondisclosure provisions further speak only in terms of institutional policy and practice, not individual instances of disclosure." *Id.*, at 288 (citation omitted). "Therefore, as in *Blessing*, they have an 'aggregate' focus." *Id.*, cit-

ing *Blessing*, 520 U.S. at 343. The Court's conclusion that FERPA's nondisclosure provisions did not confer enforceable rights was "buttressed by the mechanism that Congress chose to provide for enforcing those provisions." *Gonzaga*, at 289. That mechanism was enforcement by the Secretary of Education, who was to establish a review board to investigate and adjudicate violations of the Act.[6]

"In sum," the Court concluded in *Gonzaga*,

> if Congress wishes to create new rights enforceable under § 1983, it must do so in clear and unambiguous terms – no less and no more than what is required for Congress to create new rights enforceable under an implied right of action. FERPA's nondisclosure provisions contain no rights-creating language, they have an aggregate, not individual, focus, and they serve primarily to direct the Secretary of Education's distribution of public funds to educational institutions. They create no rights enforceable under § 1983.

Id., at 291.

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[6] In Justice Breyer's concurring opinion, joined by Justice Souter, he noted that "[m]uch of the statute's key language is broad and nonspecific." *Id.*, at 292 (Breyer, J., concurring). Under those circumstances, which could lead to uncertainty and conflicting interpretations, "Congress might well have wanted to make the agency remedy that it provided exclusive[.]" *Id.*

I. In spite of this Court's efforts in *Gonzaga* to "resolve any ambiguity" in its opinions, the courts of appeals admittedly still struggle when interpreting and applying that case law.

As discussed above, in *Gonzaga* this Court sought to "resolve any ambiguity in [the Court's] own opinions," *id.*, at 278, and to alleviate confusion in and to bring clarity to lower courts facing the issue of whether federal statutes create individual rights enforceable under § 1983. The Court's effort has not achieved its goals, however, at least in the view of some of the courts of appeals.

In *Sabree v. Richman*, 367 F.3d 180, 183 (3rd Cir. 2004), the court outlined the "three-step analysis" called for by *Gonzaga*, but cautioned that the analysis "is assuredly not for the timid[.]" The Second Circuit, in *Kapps v. Wing*, 404 F.3d 105 (2nd Cir. 2005), contrasted this Court's pre-*Gonzaga* case law with *Gonzaga* itself, observing that "the Court has appeared to be increasingly reluctant to find § 1983-enforceable rights in statutes which * * * set forth their requirements in the context of delineating the obligations that accompany participation in federal spending clause programs." *Kapps*, 404 F.3d at 127, citing *Suter* and *Gonzaga*. That court admitted that, "[i]n the aftermath of the Court's decision in *Gonzaga University*, our circuit has not yet established a unified approach to provisions contained in spending clause statutes," and suggested that its post-*Gonzaga* decisions were not necessarily consistent with each other. "*Compare Taylor v. Vermont Dep't of Educ.*, 313 F.3d 768, 786 (2nd Cir. 2002) (finding, post-*Gonzaga*, that § 1232g(a) of the Family Educational Rights and Privacy Act did not create enforceable rights), *with Rabin v. Wilson-Coker*, 362 F.3d 190, 202 (2nd Cir. 2004) (finding that § 1396r-6 of the Medicaid Act did create § 1983 enforceable rights)." *Kapps*, 404 F.3d at 127.

The First Circuit too has indicated that its post-*Gonzaga* case law may not be consistent. *Rio Grande Community Health Center, Inc. v. Rullan*, 397 F.3d 56, 73 (1st Cir. 2005) (contrasting its decision in *Bryson v. Shumway*, 308 F.3d 79, 88-89 (1st Cir. 2002), with the court's decision in *Long Term Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 56-57 (1st Cir. 2004) ("On the other hand, in *Long Term Care* * * *"), and indicating that, in *Bryson*, the court held that a Medicaid provision was enforceable based on § 1983 because, *inter alia*, "the provision included the benefited class, 'eligible individuals,' within its terms").

As these decisions illustrate, despite the Court's efforts in *Gonzaga*, confusion, uncertainty, and trepidation still persist in lower courts faced with the prospect of deciding whether particular federal statutes create private rights of action enforceable under § 1983. This Court's guidance is needed again to clarify the principles of law and the legal tests that apply to such questions.

II. Lower courts misread and misapply *Gonzaga*, and sometimes appear to ignore aspects of that decision; for those reasons, the decisions of lower courts are not faithful to *Gonzaga* and are inconsistent with each other.

As outlined above, several aspects of *Gonzaga* appear to be critical and, at least in some respects, novel. One is the Court's emphasis on explicit "rights-creating" language, and its rejection of the idea that falling within the general zone of those benefited by a federal statute is enough. *Gonzaga*, 536 U.S. at 283. Another is the decision's reliance on the fact that the federal statute at issue has an "aggregate" focus. *Id.*, at 288. The Court also looked to both the text and *structure* of the act when deciding whether the federal statute created privately enforceable rights. *Id.*, at 286. In determining whether

the statute conferred a right, as opposed to a mere benefit, the Court considered the enforcement mechanism chosen by Congress to enforce the act. *Id.*, at 289.

Some lower courts, however, appear to have misunderstood or appear to be misapplying those and other aspects of *Gonzaga*, while other courts have more faithfully followed *Gonzaga*'s teachings. Because of these inconsistent approaches and different readings of *Gonzaga*, the decisions of lower courts are in analytical conflict with each other.

Some federal courts of appeals have recognized that, as the First Circuit put it, "*Gonzaga* tightened up the *Blessing* requirements." *Rio Grande Community Health Center*, 397 F3.d at 73. That is, *Gonzaga*

> did not precisely follow the *Blessing* test but rather relied on several somewhat different factors in determining whether a right existed: whether the provision contains "rights-creating language," whether the provision has an aggregate as opposed to an individualized focus, and the other sorts of enforcement provisions that Congress has provided for.

Rio Grande, 397 F.3d at 73, citing *Gonzaga*, 536 U.S. at 287-90.

Based upon the court's understanding that *Gonzaga* signaled a "strong tilt against implied private rights," in *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d at 58, the First Circuit determined that *Gonzaga* required it to reexamine its earlier decision in *Visiting Nurses Ass'n v. Bullen*, 93 F.3d 997, 1003-05 (1st Cir. 1996), *cert. denied* 519 U.S. 1114 (2000), that had held that at least in some circumstances a provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), "could support a right of action by a provider." *Long Term Care Pharmacy*, 362 F.3d at 57. Undertak-

ing that reexamination, the court observed that "[p]rivate rights of action were once freely inferred from federal statutes that regulated conduct – and here subsection (30)(A) certainly regulates the plan provider – but the ready inference in favor of private enforcement no longer applies." *Id.* (citations omitted). "In the past," the court noted, "Long Term's best argument would have been to rely upon section 1983 as providing an explicit automatic private right of action for injunctive relief wherever federal law regulates conduct by a state entity[.]" *Id.* But "the Supreme Court recently closed that door as well in *Gonzaga*[.]" *Id.* Ultimately, "[w]hether *Gonzaga* is a tidal shift or merely a shift in emphasis," the court was "obligated to respect it, and it control[ed] th[e] case." *Id.*, at 59. Guided by *Gonzaga*, the court held that "[p]roviders such as pharmacies do not have a private right of action under subsection (30)(A)." *Id.*

Other circuit courts of appeals, including the Third, Sixth, Eleventh and, in one instance, the Ninth, have acknowledged that *Gonzaga* signals a significant shift in the analysis that applies when determining whether a federal statute creates private rights enforceable under § 1983. In *Three Rivers Center v. Housing Auth. Pitts.*, 382 F.3d 412, 419 (3rd Cir. 2004), the court carefully distinguished, as this Court did in *Gonzaga*, between being a beneficiary of a statute and being given enforceable rights by statute. The court emphasized that:

> To be sure, systematic legislation may in fact benefit a group of individuals. That does not mean that the legislation confers a personal right on those individuals. "The question whether a statute is *intended* to *benefit* particular plaintiffs is quite different from the question whether the statute *in fact benefits* those plaintiffs * * *." *Pa. Pharmacists Ass'n v.*

Houstoun, 283 F.3d 531, 535 (3rd Cir. 2002) (*en banc*) [*cert. denied*, 537 U.S. 821 (2002)].

Id. Similarly, in *Johnson v. City of Detroit*, 446 F.3d 614, 621 (6th Cir. 2006), the court noted that it had "recognized that the *Gonzaga* decision has altered the landscape of § 1983 claims." "A plaintiff can no longer satisfy the first element of the *Blessing* test simply because he or she receives a benefit from the statute at issue or is within its zone of interest." *Id.* *See also 31 Foster Children v. Bush*, 329 F.3d 1255, 1270 (11th Cir. 2003), *cert. denied sub nom Reggie B. v. Bush*, 540 U.S. 984 (2003) (focusing on *Gonzaga*'s requirements); *Sanchez v. Johnson*, 416 F.3d 1051, 1057-60 (9th Cir. 2005) (same).

In contrast to these appellate court decisions that carefully heed *Gonzaga*, other decisions, including the one at issue here, while perhaps paying lip service to *Gonzaga*, in fact slide back into the benefited-by-the-statute or zone-of-interest analysis that this Court repudiated in *Gonzaga*. In *Rabin v. Wilson-Coker*, for example, the Second Circuit concluded that a provision of the Medicaid Act, 42 U.S.C. § 1396r-6, creates private rights enforceable by recipients. The court observed that the statutory "language focuses much more directly than does the FERPA provision [considered in *Gonzaga*] on the individual's entitlement. In particular, it contains no qualifying language akin to FERPA's 'policy or practice.'" *Rabin*, 362 F.3d at 201. That analysis obscures or erases the important distinction between being a statutory beneficiary and relying on explicit rights-creating language. Similarly, in *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 603 (5th Cir. 2004), the court determined that another Medicaid provision, 42 U.S.C. § 1396a(a)(10)(A)(i), created private rights enforceable under § 1983, in part because the statutes focuses on "an identifiable class." And in *Pediatric Specialty v. Ark. Dept. of Human Serv.*, 443 F.3d 1005, 1015 (8th Cir. 2006), the court commit-

ted a parallel error, concluding that 42 U.S.C. § 1396a(a)(30)(A) – the same Medicaid provision that the First Circuit in *Long Term Pharmacy* held did not create a private right of action – did create such a right in both recipients of services and providers, in part because "[t]he *beneficiaries* are both the recipients of the services and the recipients of the state's payment[.]" (Emphasis added).[7]

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[7] While admittedly, the courts of appeals decisions regarding 42 U.S.C. § 1396a(a)(10) – the Medicaid provision that the Ninth Circuit held in this case created private rights enforceable under § 1983 – all conclude that the provision creates private enforceable rights. *Watson*, 436 F.3d at 1159-60 n. 8, citing cases. Those decisions are all distinguishable in a significant way, however. In this case, plaintiffs are not eligible for services because service priority levels 14 through 17 have been cut and because the federal agency, CMS, has approved those cuts. That fact serves to distinguish this case from the federal circuit court decisions cited and relied on by the Ninth Circuit. *Id.* at 1159-60 n. 8, 1160-61. *See Sabree*, 367 F.3d at 182 (no dispute that the plaintiffs qualified for the services they sought, but they had "languished on waiting lists"); *S.D. ex rel. Dickson*, 391 F.3d at 602 (plaintiff is eligible for services); *Westside Mothers v. Haveman*, 289 F.3d 852, 863 (6th Cir.), *cert. denied* 537 U.S. 1045 (2002) (plaintiffs are eligible for services); *Pediatric Specialty Care v. Ark. Human Services*, 293 F.3d 472, 477 (8th Cir. 2002) (state conceded plaintiffs were intended beneficiaries under the statute); *Miller v. Whitburn*, 10 F.3d 1315, 1316 (7th Cir. 1993) (no question that plaintiff was eligible for benefits). *See also Bryson*, 308 F.3d at 83, 88 (plaintiffs eligible for benefits because they were on a waiting list). Furthermore, as the State pointed out in its petition for rehearing, the Ninth Circuit appears to have analyzed this case under the wrong subsection of §

Thus, despite *Gonzaga*, "which charted a firm course among prior Supreme Court precedents in some tension with one another," *Long Term Care Pharmacy*, 362 F.3d at 57, many courts of appeals decisions still stray off-course. The decisions in this area are in a state of analytical disarray, and this Court's guidance is needed again.

Turning to a more discrete analytical conflict amongst the circuits, some courts have followed *Gonzaga* and have considered whether a statute has an "aggregate" focus, as this Court did in *Gonzaga*, 536 U.S. at 287, while others — including the Ninth Circuit in this case, 436 F.3d at 1160-61 — have treated the so-called *Suter*-fix statutes, 42 U.S.C. § 1320a-2 and 1320a-10, as though they have done away with that consideration. *Compare Rio Grande*, 397 F.3d at 74 (relying on *Suter*-fix statute to downplay the fact that the Medicaid law considered there was part of a state plan requirement); *Rabin*, 362 F.3d at 201 (same); *S.D.*, 391 F.3d at 603 (same); *with Three Rivers Center*, 382 F.3d at 430 (relying on statute's "aggregate focus" in deciding statute does not create private right of action); *Lankford v. Sherman*, 451 F.3d 496, 509 (8th Cir. 2006) (same); *Sanchez*, 416 F.3d at 1057 n. 5 (*Suter*-fix statute "does not disturb the general framework" of the analysis);[8] *31 Foster Children*, 329 F.3d at 1270 (relying on statute's aggregate focus).

1396a(a)(10). The court quoted § 1396a(a)(10)(A)(i). 436 F.3d at 1160. The pertinent subsection is § 1396a(a)(10)(A)(ii)(VI), however. That is the subsection under which the magistrate judge analyzed plaintiffs' claim. App. 15.

[8] Despite the Ninth Circuit's suggestion in its opinion in *Watson* that *Sanchez* is consistent with this case, 436 F.2d at

The analytical disagreement between the circuits continues into other areas as well. In *Gonzaga*, this Court instructed that a court should look to "the text and structure of a statute" when determining if it creates private rights enforceable under § 1983. 536 U.S. at 286. Yet post-*Gonzaga*, few courts have examined statutory structure at all. *But see, e.g., 31 Foster Children*, 329 F.3d at 1269-70 (observing that a court should examine the statutory text and structure). And when the Third Circuit attempted to analyze the statutory structure of Medicaid provisions in *Sabree v. Richman*, it encountered considerable difficulty.

> In *Gonzaga University*, the Court instructs that not only should the text of the statute be examined, but also its structure. *Gonzaga Univ.*, 536 U.S. at 286. This instruction makes good sense: we cannot presume to confer individual rights—that is a task for Congress. As the Court aptly put it, we "may play the sorcerer's apprentice but not the sorcerer himself." *Alexander v. Sandoval*, 532 U.S. at 291. Our judicial function is limited to recognizing those rights which Congress "unambiguously confers," and in doing so we would be remiss if we did not consider the whole of Congress's voice on the matter—the statute in its entirety.
>
> Turning our sights beyond the narrow provisions invoked by plaintiffs gives us some pause. Indeed, the District Court, basing its decision largely on the structural elements of Title XIX, reached the opposite conclusion from

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1161, in fact the two decisions appear to be in considerable analytical tension.

> that we reach. The District Court in large part grounded its analysis on 42 U.S.C. §§ 1396 and 1396c, and concluded that those provisions do not contain the rights-creating language required by *Gonzaga University*. *Sabree* [*v. Houston*], 245 F. Supp. 2d [653,] 659 [(E.D. Pa. 2003)]. Undoubtedly, the Court was correct in that regard.

Sabree, 367 F.3d at 191.

After considering the trial court's analysis, the appellate court rejected its conclusions, but not without acknowledging some uncertainty:

> But while the District Court correctly recognized that sections 1396 and 1396c do not contain the "sort of explicit, rights-creating language found in Title VI," it did not consider the existence of rights-creating language in other relevant provisions of Title XIX. *Sabree*, 245 F. Supp. 2d at 659. The language used by Congress in 42 U.S.C. §§ 1396a(a)(10), 1396d(a)(15), and 1396a(a)(8), however, explicitly creates rights. Admittedly, plumbing for congressional intent by balancing the specific language of a few discrete provisions of Title XIX against the larger structural elements of the statute is a difficult task. Nonetheless, it is evident, at least to us, that the statutory language, despite countervailing structural elements of the statute, unambiguously confers rights which plaintiffs can enforce.

Id. at 192. Again, this Court's instruction and guidance is needed to remind lower courts that they should examine a

statute's structure, as well as its text, and to clarify how that examination should be conducted.

In *Gonzaga*, this Court held that its conclusion that FERPA's nondisclosure provisions did not confer enforceable rights was "buttressed by the mechanism that Congress chose to provide for enforcing those provisions." 536 U.S. at 289. That is another analytical instruction that has been largely ignored post-*Gonzaga* (and that the Ninth Circuit overlooked in this case). *But see 31 Foster Children*, 329 F.3d at 1269-70 (noting that aspect of this Court's decision in *Gonzaga*); *Rio Grande*, 397 F.3d at 73 (same); *Long Term Care Pharmacy*, 362 F.3d at 58 ("Under *Gonzaga*, the presence of an explicit [federal agency] enforcement mechanism weighs against inferring private rights of action"). This Court should grant certiorari in order to clarify the role that federal enforcement of Spending Clause statutes plays in the analysis.

Post-*Gonzaga*, courts also are divided with regard to how seriously and how literally they take the Court's use in *Gonzaga* of Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972 as exemplars of statutes that "create individual rights because those statutes are phrased 'with an *unmistakable focus* on the benefited class.'" 536 U.S. at 284, quoting *Cannon v. University of Chicago*, 441 U.S. 677, 691 (1979) (emphasis added in *Gonzaga*) (footnote omitted). Each of those statutes is phrased in unmistakable rights-creating language because each begins with the phrase "*No person* in the United States *shall* * * * be subjected to discrimination[.]" *Gonzaga*, at 284 n. 3, setting out 43 U.S.C. § 2000d and 20 U.S.C. § 1681(a) (emphasis added in *Gonzaga*).

Some decisions treat those examples as indicating how express and clear rights-creating language must be. *See, e.g. Sanchez*, 416 F.3d at 1058 ("Although our inquiry should not

be limited to looking for those precise phrases, statutory language less direct than the individually-focused "No person shall * * *" must be supported by other indicia so unambiguous that we are left without any doubt that Congress intended to create an individual, enforceable right remediable under § 1983"). Other decisions seem to stretch the comparison between the statutory language cited by this Court in *Gonzaga* and the statutory language being examined by the court well beyond the breaking point. *See, e.g., Sabree*, 367 F.3d at 190 (suggesting that it is "difficult, if not impossible, as a linguistic matter, to distinguish the import of the relevant [Medicaid Act] language – 'A State plan must provide' – from the 'No person shall' language of Titles IV and IX").[9] Again, the appellate court decisions are in conflict – a conflict that this Court should resolve.

CONCLUSION

Although this Court set out to clarify the applicable law in *Gonzaga*, the decisions of the lower courts remain in analytical disarray despite the Court's course correction. That analytical disarray makes it difficult, if not virtually impossible, for States to predict accurately which Spending Clause statues will expose state officials to actions brought by individuals under § 1983. Yet in Spending Clause legislation "'Congress must express clearly its intent to impose conditions on the grant of federal funds so that the States can knowingly decide whether or not to accept those funds.'" *Wilder*, 496 U.S. at 511, quoting *Pennhurst*, 451 U.S. at 24 (footnote omitted). It does little good to require that Congress speak clearly if the courts do not and if their decisions cannot be predicted. For the reasons given above, this Court should grant the petition

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[9] The Ninth Circuit quoted and relied on that passage in *Watson*, 436 F.3d at 1160.

for a writ of certiorari and clarify this important area of the law.

Respectfully submitted,

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September 29, 2006

APPENDIX

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF OREGON

WILLIAM W. WATSON, JR.; ROBERT WOODFORD, by and through his next friend, ANITA GEISTLINGER; HEIDI HALTER, by and through her next friend HAYLEY ADAMS; CHARLES E. PAPST, JR., by and through his next friend NIDA MORRIS; AMAR JUSLEN by and through his next friend, RAUL JUSLEN; IRMA RADTKE by and through her next friend HANS RADTKE; SHELLI A. CAMERON; and OREGON ADVOCACY CENTER,

Plaintiffs,

vs.

JEAN THORNE, in her official capacity as Director of the Oregon Department of Human Services; LYNN READ, in her official capacity as Acting Administrator of the Office of Medical Assistance Programs; and JAMES TOEWS, in his official capacity as Acting Administrator, Seniors and People with Disabilities,

Defendants.

Civil No. 03-227-JE

FINDINGS AND RECOMMENDATION

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JELDERKS, Magistrate Judge:

Plaintiffs are seven individuals who have received health care assistance through the Oregon Home and Community Based Services Waiver (HCBS waiver), and the Oregon Advocacy Center. They bring this action pursuant to 42 U.S.C. § 1983 against Jean Thorne, Director of the Oregon Department of Human Services (OHDS); Lynn Read, Acting Administrator of the Office of Medical Assistance Programs; and James Toews, Acting Administrator of the Seniors and People with Disabilities program. Plaintiffs challenge the State of Oregon's authority to reduce services provided to individuals under the HCBS waiver program.

Defendants move to dismiss plaintiffs' first four claims, which allege that defendants' determinations of eligibility and termination of benefits were unlawful, for failure to state a claim upon which relief may be granted. Both defendants and plaintiffs move for summary judgment on the fifth claim, which alleges that the notice of termination of benefits provided to plaintiffs was inadequate. I recommend granting defendants' motion to dismiss the first four claims, granting defendants' motion for summary judgment on the fifth claim, and denying plaintiffs' motion for partial summary judgment.

BACKGROUND

1. Relevant action by State of Oregon concerning Medicaid benefits

This action arises from Oregon's participation in the Medicaid program, a cooperative federal-state Medical Assis-

tance Program authorized by Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. The Medical Assistance Program, which is administered by the State of Oregon, pays for certain health care services provided to eligible low-income individuals. ORS § 414.025 et seq. Oregon must comply with federal Medicaid requirements in order to receive matching funds from the federal government. 42 U.S.C. § 1396 et seq.

States participating in Medicaid must submit a "State Plan" for approval by the Secretary of the Department of Health and Human Services (HHS). 42 U.S.C. § 1396; 42 C.F.R. § 430.10. States must pay for certain services, and may elect to pay for other services as well. 42 U.S.C. § 1396a(a)(10)(A). States proposed Medicaid plains are reviewed by the federal Centers for Medicare and Medicaid Services (CMS), which was formerly known as the Health Care Financing Administration (HCFAA), for approval. A state Medicaid plan sets out the extent of the state's participation in the Medicaid program.

States that choose to participate in the Medicaid program must provide services to individuals who qualify as "categorically eligible" for services, and have the option of providing services to other categories of individual as well.

Medicaid pays for long term care of eligible elderly and disabled individuals if care is provided in nursing homes or institutions: Medicaid does not require states to offer alternatives such as in-home or community-based services, and ordinarily does not pay for such services. However, under Title XIX, states have the option of providing home and community-based services as an alternative to providing care in nursing facilities. 42 U.S.C. § 1396a(a)(10)(A)(ii)(VI). In order to provide alternatives to institutional inpatient care, states may request waiver of certain federal Medicaid requirements so they can develop treatment alternatives to the institutional

care that would be covered by Medicaid requirements so they can develop treatment alternatives to the institutional care that would be covered by Medicaid. If a waiver is approved, any subsequent changes to the state waiver program must be submitted to CMS for review and approval.

On December 23, 1981, the Oregon Department of Human Services (DHS) applied for an HCBS waiver to allow Oregon to provide in –home and community-based services to individuals who would otherwise need to be cared for in institutional nursing facilities. Subsequent approval of the HCBS waiver eliminated the general Medicaid requirement that Medicaid recipients reside in a nursing facility or comparable medical institution in order to receive comprehensive long-term care services. Oregon's standards for eligibility for HCBS waiver program services, which includes 18 Service Priority Levels and the Client Assessment and Planning System (CA/PS) used to determine those priority levels, were also approved.[1]

Through waiver amendments and renewals, Oregon added a number of services to those allowed under the initial waiver. The currently approved HCBS waiver, which took effect on October 1, 2001, allows Oregon to provide respite care, adult day health services, environmental accessibility adaptations, transportation, adult residential care, home delivered meals,

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[1] This system assesses "daily living activity" factors, including (1) bathing/personal hygiene; (2) cognition/behavior; (3) dressing/grooming; (4) eating; (5) elimination; and (6) mobility to evaluate potential recipients' "Service Priority Level." Level 1 reflects the highest need and priority for services, and level 18 reflects the lowest need and priority. Before the reductions giving rise to this action, individuals assessed at levels 1 through 17 were eligible for services.

specialized living services, in-home services, and residential care facility services to individuals who, without the waiver, would require care in an institutional nursing facility.

Because of Oregon's budget problems, ODHS recently reduced the population served under the HCBS waiver. ODHS submitted an amendment to Oregon's HCBS waiver on January 27, 2003, in order to eliminate Service Priority Levels 15, 16, and 17 from the waiver population. The amendment stated that this change would reduce the HCBS waiver population by approximately 4,000 individuals who were receiving in-home and community-based services, and approximately 85 individuals who were receiving services in nursing facilities.

CMS approved amendment of the waiver. Following the amendment, ODHS cannot seek any federal funds to help cover the cost of providing any waivered services to those individuals. Administrative rules were revised following the amendment, and the affected individuals in Service Priority Levels 15-17 were given notice of the termination of service, their right to request reassessment of their level, and their right to request a hearing concerning their assessment.

In the amendment, CMS sought approval for Community Transition Services to assist recipients who were losing their eligibility for benefits.

On February 24, 2003, ODHS submitted a second amendment to CMS. This amendment stated that services for the HCBS waiver population in Service Priority Levels 10 through 14 would also be eliminated. The amendment stated that the change would eliminate services to approximately 6,100 individuals receiving in-home and community-based care, and would eliminate services for approximately 300 individuals in nursing facilities. Administrative rules were again revised to reflect the change, and notice was sent informing

individuals in Service Priority Levels 10 through 14 of the termination of service, their right to request reassessment of their service priority level, and their right to a hearing. The amendment stated that local staff would assist clients to find alternatives to the waivered services being eliminated, and requested approval of Community Resource Development services to assist with the transition.

The Oregon Legislature subsequently restored funding for Service Priority Levels 10 and 11 through June 30, 2003. Accordingly, ODHS filed an amendment to the waiver with CMS to reflect this change on March 31, 2003, and administrative rules were adopted reflecting the change. On April 7, 2003, the CMS Seattle Regional Office staff indicated that approval of amendments deleting Service Priority Levels 12 through 17 from the HCBS waiver program would be recommended, and Oregon's request to eliminate Levels 15 through 17 was granted on April 29, 2003.

CMS approval is the only federal action needed to delete affected individuals from the HCBS waiver program. After CMS approval of the HCBS waiver takes effect and administrative rules are adopted implementing the changes instituted with the waiver, Oregon cannot obtain federal financial participation for any waivered services provided to these individuals.

2. Effect of these decisions on plaintiffs

Plaintiffs are individuals whose serious medical problems and cognitive limitations require that they either be cared for in a nursing facility or receive an equivalent level of care in community settings. Plaintiffs have received care through the HCBS waiver of the Oregon Medicaid program described above.

Following the recent rule changes, plaintiffs will no longer be eligible for the level of care provided in nursing fa-

cilities. This means that they will not be able to receive funding for either HCBS waiver services or care in nursing facilities. The change in eligibility criteria disqualifies plaintiffs from all Medicaid-funded long-term care services.

PLAINTIFFS' CLAIMS

Plaintiffs allege that Oregon has chosen to provide optional home and community-based services and nursing home care to eligible elderly and disabled individuals under a waiver approved by CMS. Plaintiffs allege that they were eligible for home or community-based services under the HCBS waiver program before this biennium, when the legislature cut funding for Service Priority Levels 10 through 17.

Plaintiffs allege that they were each sent a notice of termination of benefits stating that "we cannot grant a hearing over the termination of service priority levels [15 through 17 or 10 through 14]. However, you have a right to a hearing if you disagree with your service level assessment." Plaintiffs have all requested a hearing concerning their service level assessment.

The first claim alleges that termination of plaintiff's services under the HCBS waiver violates the Medicaid Act, 42 U.S.C. §§ 1396a(a)(10) and 1396d(a)(4)(A).

The second claim alleges that defendants violated 42 U.S.C. §§ 1396, 1396a(a)(17), 1396d(f), and 1396(c)(1) by failing to apply reasonable standards for eligibility for HCBS waivered services, and by terminating plaintiffs' receipt of waivered services. Plaintiffs allege that they are no longer eligible for waivered services only because of budget cuts, and not because of any change in their condition. Plaintiffs allege that defendants' application of an "unreasonable" eligibility standard violates the Medicaid Act.

The third claim alleges that defendants violated 42 U.S.C. §§ 1396, 1396a(a)(17), 1396d(f), and 1396 n(c)(1) by "fail[ing] to establish and employ reasonable standards" for determining their eligibility for services under the HCBS waiver program.

The fourth claim alleges that termination of their receipt of waivered services violates 42 U.S.C. § 1396a(a)(10)(B). That section requires that medical assistance provided under Medicaid programs not vary by "amount, duration or scope" among the beneficiaries. The fourth claim also alleges that termination of benefits violated regulations implementing that statute.

The fifth claim alleges that the notice of termination of benefits provided plaintiffs was inadequate, and that this inadequacy violated the Medicaid Act and the federal Due Process Clause.

Plaintiffs allege that all of their claims are actionable under 42 U.S.C. § 1983, and seek declaratory and injunctive relief.

In an Order filed on June 16, 2003, the Honorable Ancer Haggerty denied plaintiffs' motion for preliminary injunctive relief. Judge Haggerty concluded that plaintiffs failed to establish "a high likelihood of success" on their claims.

STANDARDS FOR EVALUATING MOTIONS TO DISMISS FOR FAILURE TO STATE A CLAIM UPON WHICH RELIEF MAY BE GRANTED

In evaluating a motion to dismiss for failure to state a claim pursuant to Fed. R. Civ. P. 12(b)(6), the court must accept the allegations of material fact as true, and must construe those allegations in the light most favorable to the non-moving party. Parks Sch. of Bus. v. Symington, 51 F.3d 1480, 1484 (9th Cir. 1995). A claim should be dismissed only if it appears

beyond doubt that the plaintiff can establish no set of facts under which relief could be granted. Pacheco v. United States, 220 F.3d 1126, 1129 (9th Cir. 2000).

STANDARDS FOR EVALUATING MOTIONS FOR SUMMARY JUDGMENT

Federal Rule of Civil Procedure 56(c) authorizes summary judgment if no genuine issue exists regarding any material fact and the moving party is entitled to judgment as a matter of law. The moving party must show the absence of an issue of material fact. Celotex Corp. v. Catrett, 477 U.S. 317, 325 (1986). The moving party may discharge this burden by showing that there is an absence of evidence to support the nonmoving party's case. Id. When the moving party shows the absence of an issue of material fact, the nonmoving party must go beyond the pleadings and show that there is a genuine issue for trial. Id. at 324.

The substantive law governing a claim or defense determines whether a fact is material. T.W. Elec. Serv., Inc. v. Pacific Elec. Contractors Ass'n, 809 F.2d 626, 630 (9th Cir. 1987). Reasonable doubts concerning the existence of a factual issue should be resolved against the moving party. Id. at 630-31. The evidence of the nonmoving party is to be believed, and all justifiable inferences are to be drawn in the nonmoving party's favor. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 255 (1985). No genuine issue for trial exists, however, where the record as a whole could not lead the trier of fact to find for the nonmoving party. Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 587 (1986).

DISCUSSION

Plaintiffs assert that their claims concerning eligibility for benefits, termination of benefits, and notice are actionable under § 1983. Defendants disagree. They contend that the allegations set out in the first four claims fail to state a claim be-

cause the alleged violations do not implicate actionable "rights." Defendants contend that they are entitled to summary judgment on the fifth claim because the notice provided met constitutional standards.

I. Claims 1-4: eligibility and termination of benefits

A. Standards for determining whether claims are actionable under § 1983

Section 1983 allows individuals alleging "deprivations of any rights, privileges, or immunities secured by the Constitution and laws" of the United States to bring claims in federal court.

In appropriate circumstances, § 1983 applies not only to violations of the United States Constitution, but to violations of federal statutes as well. Maine v. Thiboutot, 448 U.S. 1, 6-8 (1980). However, in order to obtain relief pursuant to § 1983, a plaintiff must establish that the violation of a federal statute has resulted in the violation of a federal right. Golden State Transit Corp. v. City of Los Angeles, 493 U.S. 103, 106 (1989). Actions based upon an alleged violation of a federal statute may be brought under § 1983 only if the relevant statute creates "enforceable rights, privileges, or immunities within the meaning of § 1983," and Congress has not foreclosed a plaintiff's ability to rely on § 1983 as a means of enforcement of those rights. Wright v. City of Roanoke Redevelopment and Housing Authority, 479 U.S. 418, 423 (1987).

In Blessing v. Freestone, 520 U.S. 329, 340-41 (1997), the Court applied a three-part test for determining whether alleged statutory violations are actionable under § 1983. Under this test, a violation of a federal statue constitutes an actionable violation of a federal right if 1) Congress "intended that the provision in question benefit the plaintiff," 2) the plaintiff demonstrates "that the right assertedly protected by the statute is not so 'vague and amorphous' that its enforcement would

strain judicial competence," and 3) the provision in question is "couched in mandatory, rather than precatory, terms." Id.

In Gonzaga University v. Doe, 536 U.S. 273, 282-83 (2002), the United States Supreme Court recently clarified that Blessing does not stand for the proposition that plaintiffs may enforce a statute under § 1983 simply because they were "within the general zone of interest that the statute is intended to protect." The Court unequivocally rejected "the notion" that "anything short of an unambiguously conferred right" will support a claim brought under § 1983, stressing that "it is *rights*, not the broader or vaguer 'benefits' or 'interests,' that may be enforced under the authority of [§ 1983]."[2] Id. at 283. It added that, in determining whether a private right of action exists which allows a plaintiff to bring a claim for alleged statutory violation under § 1983, a court "must first determine whether Congress *intended to create a federal right*." Id. (emphasis in original).

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[2] Defendants assert that the three-part test set out in Blessing "has been disavowed by the Supreme Court" in the Gonzaga decision. Defendants' reply brief at 3. However, though the Gonzaga Court cited Blessing as one of the opinions that "might have been read to suggest that something less than an unambiguously conferred right is enforceable by § 1983," its discussion is more fairly characterized as a clarification than disavowal of Blessing. The Ninth Circuit's conclusion that the three-part test has not been repudiated is reflected in its recent observation that determining whether a statute confers an individual right "normally would involve an application of the Supreme Court's three-prong Blessing test. . . ." Save Our Valley v. Sound Transit, 335 F.3d 932, 943 n. 10 (9th Cir. 2003).

This inquiry requires "a determination as to whether or not Congress intended to confer individual rights upon a class of beneficiaries." Id. at 285. The question is not simply whether a particular class of persons benefits from a statute, but whether Congress intended to confer "federal rights" on them. Id. at 286 (citations omitted). If the statutory "text and structure" do not indicate "that Congress intends to create new individual rights, there is no basis for a private suit" under § 1983. Id. Statutory provisions that do not include "rights-creating language," and "have an aggregate, not individual, focus" do not create "rights enforceable under § 1983." Id. at 290.

B. Application to claims based upon eligibility for and termination of benefits

In analyzing whether the first four claims are actionable under § 1983, the threshold question is whether Congress conferred statutory rights on the "particular class of persons" to which plaintiffs belong. The question is not whether there are any Medicaid provisions that give rise to actionable individual rights, but whether the particular statutes upon which plaintiffs rely confer actionable individual rights.

In analyzing this issue, I have examined the "text and structure" of relevant Medicaid provisions. The HCBS waiver program exists under the Medicaid Act, which Congress established pursuant to its spending power under Article I, § 8 of the Constitution. Under that authority, Congress may establish the terms under which federal funds are provided to states participating in programs dispersing federal funds. E.g., Pennhurst State School and Hospital v. Halderman, 451 U.S. 1 (1981). The usual remedy for a state's failure to comply with statutory requirements is not a private right of action, but discontinuation of federal funding. Id. at 28. Since Pennhurst, the Supreme Court has only twice found that spending legisla-

tion gives rise to individually enforceable rights. Gonzaga, 536 U.S. at 280 (citing Wright v. City of Roanoke Redevelopment and Housing Authority, 479 U.S. 418 (1987); Wilder v. Virginia Hospital Ass'n, 496 U.S. 498 (1990)).

Based upon my examination of the statutes in question, I conclude that Congress did not unambiguously confer personal rights under the HCBS waiver program that are actionable under § 1983. The relevant sections of Title XIX do not expressly or impliedly require states to provide the home and community-based services to the elderly and disabled at issue here. Instead, these are optional services provided under a § 1915(c) waiver program which the states are not required to offer. Under this optional program, with approval of CMS, a state may change the services it offers and reduce the population served. Under applicable regulations, a state may terminate an HCBS waiver program for any reason upon 30 days notice to CMS and the program beneficiaries. 42 C.F.R. § 441.356. In addition, the Medicaid Act allows states to limit the class of individuals who receive benefits based upon the funds made available by the state legislature. These characteristics are inconsistent with the conferral of actionable rights to continued eligibility and receipt of benefits.

Termination claims

Claim 1

The first and fourth claims challenge the termination of plaintiffs' benefits. In support of their first claim, plaintiffs contend that they have actionable rights to receive continued services because 42 U.S.C. § 1396a (a)(10)(A) "sets forth a Medicaid program's required services, and designates the persons to whom those services must be made available." Plaintiffs argue that, because Oregon chose the "Nursing facility level of care" under that section, Medicaid-eligible individu-

als who need the level of care provided in a nursing facility have the right to receive benefits under the HCBS waiver.

Section 1396a(a)(10)(A)(ii)(VI) describes the individuals for whom a state is required to provide medical assistance. This provision also requires state plans to include home and community-based services for elderly and disabled persons who qualify for Medicaid if a state "at its option" has chosen to provide such services "pursuant to a waiver granted by the Secretary."

This section does not include the kind of "rights-creating" language that the Gonzaga Court cited as indicative of an intent to confer rights that may be asserted by individuals under § 1983. Instead, it addresses "aggregate" rights as opposed to individual rights, and focuses on what a state must do to be eligible for federal funding. Emphasis on aggregate populations and the regulated entity is inconsistent with "'an intent to confer rights on a particular class of persons.'" Gonzaga, 536 U.S. at 287(quoting California v. Sierra Club, 451 U.S. 287, 294 (1981)). Though the terms of this section may indicate that plaintiffs are within the "general zone of interest that the statute is intended to protect," they fall short of describing the kind of "unambiguously conferred right" necessary to render the statute actionable under § 1983. Section 1396 addresses what a state must do to qualify for federal funding. A state's failure to meet those requirements logically results in a loss of funding, not the creation of individual rights of recipients to continue to receive benefits.

Plaintiffs also allege that the State of Oregon cannot terminate their benefits because doing so would violate 42 U.S.C. § 1396d(a)(4)(A), which defines "medical assistance" as including payment for the costs of nursing facility services. However, this definition does not constitute an unambiguous conferral of individual rights. Instead, it simply lists the ser-

vices that a state must include in its plan in order to receive federal funding. In imposing conditions on a state's receipt of federal funds, this section focuses on the entity that is regulated, and does not indicate an intent to confer actionable rights on a class of Medicaid recipients. Medicaid does not set out any uniform federal standard for determining qualifications to receive benefits, but instead seeks to enable "each State, as far as practicable under the conditions in such State," to furnish assistance to those made eligible under an approved state plan for medical assistance. 42 U.S.C. § 1396. In this context, § 1396(a)(4)(A) is logically interpreted as simply requiring states to provide payments for nursing facility services to those who qualify for those services under a state plan. Nothing in that section explicitly or implicitly prohibits a state from reducing the number of persons who receive such services because of budget restraints.

Claim Four

Plaintiffs' fourth claim asserts that the termination of plaintiffs' benefits violated 42 U.S.C. § 1396a(a)(10)(B) and implementing regulations set out at C.F.R. §§ 440.230(b) and (c). Section 1396a(a)(10)(B) requires that services provided under a Medicaid program not vary in "amount, duration or scope" among eligible Medicaid beneficiaries. The cited regulations require that each service be "sufficient in amount, duration, and scope to reasonably achieve its purpose," and prohibit arbitrary denial or reduction in "the amount, duration, or scope of a required service . . . to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition."

Before addressing the portion of this claim that is based upon the cited statute, I note that the Ninth Circuit has recently held that violation of a regulation does not give rise to an actionable claim. In Save Our Valley, 335 F.3d at 943, the

court unequivocally held "that an agency regulation cannot create an individual federal right." Though regulations "may be relevant in determining the scope of the right conferred by Congress," plaintiffs asserting rights pursuant to § 1983 "must demonstrate that a *statute* – not a regulation – confers an individual right." Id. (citing South Camden Citizens in Action v. New Jersey Dept. of Environmental Protection, 274 F.3d 771, 781-83 (3d Cir. 2001). To the extent that plaintiffs' fourth claim is based upon an alleged violation of a regulation, it therefore must fail.

Section 1396a(a)(10)(B) requires that a state plan for medical assistance provide that assistance not vary by "amount, duration or scope" among the beneficiaries. Plaintiffs allege that the reduction of the population served by the HCBS waiver and termination of plaintiffs' services "draws illegal and illogical distinctions" between beneficiaries who are entitled to receive comparable services.

Section 1396a (a)(10)(8) does not confer rights that are actionable by individuals. In requiring that state plans for medical assistance provide equal services to individuals qualifying for benefits, this provision simply describes features that a state must include in its plan in order to be eligible for federal funding under Medicaid. The provision does not include the kind of "rights-creating language" that confers actionable rights: it does not focus on potential recipients, but instead focuses on the Secretary's authority to make federal funds available to the states under plans approved by the Secretary. Under the guidance of Gonzaga, I conclude that this section does not create actionable rights.

Eligibility Claims

Claims 2 and 3

Plaintiffs second and third claims allege that defendants have violated 42 U.S.C. §§ 1396, 1396a(a)(17), 1396d(f), and

1396n(c)(1) by using unreasonable standards for determining plaintiffs' eligibility for long term care services, and by assigning unqualified persons to assess their conditions.

Section 1396 simply states that the purpose of Title XIX, the Medicaid statute, is to enable "each State, as far as practicable under the conditions of each State," to provide medical assistance to those who lack the resources to meet the costs of necessary medical services.

Section 1396a(a)(17) requires state plans for medical assistance to include reasonable standards, which are consistent with the objectives of the medicaid program, for determining eligibility for medial assistance.

Section 1396d(f) defines "nursing facility" services.

Section 1396n(c)(1) allows the Secretary to "provide that a State plan... may include as 'medical assistance' under such plan payment for part or all of the cost of home or community-based services . . . which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan."

These provisions, like the other sections cited above, do not set out the kind of "unambiguously conferred rights" that will support a claim under § 1983. These provisions instead reflect the sort of "aggregate" focus that is inconsistent with the creation of individual "rights." Like the other provisions discussed above, these sections focus on what a state must do to comply with the Act and receive federal funds rather than on the rights of affected individuals who may receive benefits. Section 1396 simply states that Medicaid is intended to enable each state to provide medical assistance to those who lack re-

sources to the extent that is practical under the conditions existing in each state. Because no particular level of assistance is mandated, a state's financial resources must logically be considered as one of the relevant state "conditions."

Section 1396a(a)(17) does not create rights actionable under § 1983 because it allows each state to exercise its discretion in adopting reasonable standards for determining eligibility. In addition, the provision of a mechanism under § 1396a(a)(c) for state administrative review of claimants' assertions that errors have been made in determining their eligibility or the amount which they will receive supports the conclusion that Congress did not intend to create rights enforceable under § 1983. See Gonzaga, 536 U.S. at 290 (existence of procedures for administrative review counsels against "finding a congressional intent to create individually enforceable private rights").

Section 1396d(f) simply provides definitions, and cannot be characterized as giving rise to substantive rights to the services described.

Since the Supreme Court's clarification of the analysis of when a statutory violation is actionable pursuant to § 1983, most courts considering the issue have held that § 1396 of the Medicaid Act does not give rise to individually enforceable rights. See M.A.C. v. Betit, 2003 WL 22119134, ___ F. Supp. ___, (D. Utah 2003); Sabree v. Houston, 245 F. 30 Supp. 2d 653 (E.D. Pa. 2003); Belen Consolidated Schools v. Otten, 259 F. Supp. 2d (D. N.M. 2003); Burlington United Methodist Family Services, Inc. v. Atkins, 227 F. Supp. 2d 593 (S.D. W.Va. 2002); Wilson-Coker v. Community Visiting Nurse and Home Care Agency, Inc., 222 F. Supp. 2d 190 (D. Conn. 2002). These decisions are more consistent with Gonzaga than are the two decisions from the First Circuit on which plaintiff relies that have reached a contrary conclusion. See

Bryson v. Shumway, 308 F.3d 79 (1st Cir. 2002); Rolland v. Romney, 318 F.3d 42 (1st Cir. 2003). Addressing a section of the Medicaid statutes that plaintiffs do not rely on here, the Bryson court did not consider the absence of "rights-creating language" and the "aggregate, not individual focus" of the statute in question--factors that the Gonzaga Court considered critical. The Rolland court likewise did not fully consider the factors set out in Gonzaga.

Based upon my review of the relevant statutes and cases, I conclude that Congress did not intend to create "rights" enforceable by individuals under the statutes upon which plaintiffs' first four claims are based. In the absence of such rights, the first four counts of plaintiffs' complaint do not state claims upon which relief may be granted.

II. Fifth claim: notice

Plaintiffs were informed that their benefits would be terminated in notices that stated:

> NOTICE OF TERMINATION OF BENEFITS
>
> This notice is about an important change. You have been receiving services in your home or in a setting such as an Adult Foster Home, a Residential Care Facility, an Assisted Living Facility or a Nursing Facility. We are sorry to tell you that those services will end on March 31, 2003. Your care provider will not be paid for services after that date.
>
> Your services are ending because the program that provides Medicaid services for priority levels [15 through 17 or 10 through 14] will end [January 31, 2003 or March 31, 2003]. Based on an assessment by a case manager, your service priority level is [ ]. Information to

help you understand the different levels is enclosed. The reason for this change is because the State of Oregon does not have enough money to continue to fund the program that provides the services you are receiving.

Because these changes affect all persons like yourself in service levels [15 through 17 or 10 through 14] whose services are being eliminated statewide, we cannot grant a hearing based on the limitation of services. However, you have a right to a hearing if you disagree with your service level assessment. This assessment is what determined you were in a service level between [15 and 17 or 10 and 14]. It may be possible to continue your services until a decision is reached on your hearing. On the back of this form, Part 1 tells you how to request a hearing and Part 2 tells about continuing your benefits.

Your eligibility for a medical card will not be affected by this change.[3]

Your case manager will be able to answer any questions you may have and to discuss any other services that may be available to you.

This notice is based on Oregon Administrative Rules 411-015-0000 through 411-015-0015 and 411-030-0002 through 411-030-0080, and on 42 CFR 431.220(b).

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[3] The notices sent to some of the plaintiffs stated: "[b]ecause your services are ending, your eligibility for a medical card may change. You will receive a separate notice that explains these changes."

Plaintiffs' fifth claim alleges that these notices are "defective and deficient" because they:

> -fail to contain an adequate statement of the reasons for Defendants' action;
>
> -fail to contain an adequate statement of the specific regulations that support the change;
>
> -fail to include an adequate explanation of plaintiffs' right to a hearing or the circumstances under which a hearing will be granted; and
>
> -fail to include an adequate explanation of the circumstances under which Medicaid will be continued if a hearing is requested.[4]

Plaintiffs allege that "[t]hese failures constitute a violation of the Medicaid Act and the controlling Medicaid regulations, 42 CFR § 431.200 et seq., and the Due Process Clause of the 14th Amendment of the U.S. Constitution, and are actionable under 42 USC § 1983."

Defendants do not assert that plaintiffs had no actionable "right" to proper notice. Instead, they contend that the notices provided to plaintiffs satisfied the requirements of both the regulations and Constitutional due process.

The Ninth Circuit's recent holding that "an agency regulation cannot create an individual federal right" casts doubt on the correctness of the parties' apparent agreement that plaintiffs may base their fifth claim in part on alleged failure to comply with the standards set out in 42 C.F.R. § 431.200 et

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[4] In their response to defendants' concise statement of material facts, plaintiffs' have withdrawn their allegation that the notices were also defective because they were not sent in alternative formats to Plaintiffs with visual impairments.

seq.. Save Our Valley, 335 F.3d at 943. Nevertheless, because agency regulations may be relevant in determining the scope of statutory rights, and because defendants do not challenge plaintiffs' assertion that they set out the appropriate standard, I will consider these regulations in analyzing the parties' cross motions for summary judgment on the fifth claim. Consideration of the regulations is also appropriate because they appear to be fully consistent with the notice requirements generally applicable to the termination of benefits like those at issue here. See, e.g., Raditch v. United States, 929 F.2d 478, 480 (9th Cir. 1991) (citing Goldberg v. Kelly, 397 U.S. 254, 262 (1970)) (recipients of disability benefits have property interest that cannot be terminated without due process); Cleveland Bd. of Education v. Loudermill, 470 U.S. 532, 546 (1985) (termination of a government-created property interest requires notice and an opportunity to respond).

Under the terms of 42 C.F.R. § 431.201, defendants were required to provide plaintiffs notices that included:

> (a) a statement of what action the State intended to take;
>
> (b) the reasons for the intended action;
>
> (c) the specific regulations that support, or the change in law that requires, the action;
>
> (d) an explanation of --
>
> > (1) the individual's right to request an evidentiary hearing if one is available, or a State agency's hearing; or
> >
> > (2) where the action is based on a change in law, the circumstances under which a hearing will be granted; and

> (e) an explanation of the circumstances under which Medicaid will be continued if a hearing is requested.

Plaintiffs contend that the notices were not adequate because the assertion that the termination of benefits resulted from termination of the "program that provides Medicaid services for service levels [15 through 17 or 10 through 14]" was incorrect, because the HCBS Waiver program itself was not ending. They contend that the notices were confusing because they referred to more regulations than necessary, and assert that the failure to include "succinct detail . . . reflects a clear attempt to mislead the Plaintiffs. . . ." Plaintiffs further contend that, because they stated both that hearings were not available because the terminations were based upon service levels, and that recipients could request a hearing if they disagreed with their service level assessment, the notices confused recipients and discouraged them from requesting a hearing.

I disagree, and conclude that defendants' motion for summary judgment on this claim should be granted. Defendants were not required to provide the best notices possible, or notices that would necessarily be perfectly understood by every recipient. Instead, they were required to provide notices that complied with § 431.210 and the less explicit requirements of Constitutional due process. The notices correctly informed the recipients of what action would be taken on particular dates and accurately cited lack of sufficient funds as the reason for the termination of services. The notices cited regulations that supported the action, described the service priority levels, and explained eligibility for in-home service programs. They informed the recipients that hearings would not be granted regarding the overall termination of services, and cited the regulation authorizing the agency not to grant hearings if the issue was a law requiring an automatic change that adversely af-

fected some or all recipients. The notices informed recipients of their right to a hearing if they disagreed with their individual service level assessment. They advised recipients that it might be possible to continue services until a decision was reached on a hearing, and referred the recipients to the back of the form, which included an explanation of how to request a hearing and continuing benefits.

It is true the entire HCBS waiver program under which the recipients' were receiving benefits was not ending. However, the program was ending as to the recipients' service levels. The notices accurately stated the levels that were scheduled for termination, and informed the recipient of his or her service level. The assertion that recipients could not challenge termination of benefits to a particular service level because the benefits for all recipients at that level were being terminated was correct, as was the assertion that a recipient could challenge his or her service level assessment. These statements were not unnecessarily complicated or confusing, and in no way discouraged requests for a hearing by implying that a challenge to the assessment level would be futile. The regulations cited in the notices were relevant to the changes requiring the terminations at issue, and the reference to them was therefore appropriate.

Under these circumstances, a reasonable trier of fact could not conclude that the notices violated the relevant regulation or failed to provide plaintiffs the due process to which they were entitled. Defendants' motion for summary judgment on the fifth claim should therefore be granted, and plaintiffs' cross motion for summary judgment on this claim should be denied.

CONCLUSION

Defendants' motion to dismiss and for summary judgment (#14) should be GRANTED, and plaintiffs' cross motion for

summary judgment on the fifth claim (#53) should be DENIED.

SCHEDULING ORDER

The above Findings and Recommendation are referred to a United States District Judge for review. Objections, if any, are due December 10, 2003. If no objections are filed, review of the Findings and Recommendation will go under advisement on that date.

A party may respond to another party's objections within 10 days after service of a copy of the objection. If objections are filed, review of the Findings and Recommendation will go under advisement upon receipt of the response, or the latest date for filing a response.

DATED this 24th day of November, 2003.

/s/ John Jelderks
John Jelderks
U.S. Magistrate Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

WILLIAM W. WATSON, JR.; ROBERT WOODFORD, by and through his next friend, ANITA GEISTLINGER; HEIDI HALTER, by and through her next friend HAYLEY ADAMS; CHARLES E. PAPST, JR., by and through his next friend NIDA MORRIS; AMAR JUSLEN by and through his next friend, RAUL JUSLEN; IRMA RADTKE by and through her next friend HANS RADTKE; SHELLI A. CAMERON; and OREGON ADVOCACY CENTER,

Plaintiffs,

vs.

JEAN THORNE, in her official capacity as Director of the Oregon Department of Human Services; LYNN READ, in her official capacity as Acting Administrator of the Office of Medical Assistance Programs; and JAMES TOEWS, in his official capacity as Acting Administrator, Seniors and People with Disabilities,

Defendants.

Case no. 03-227-JE

ORDER

HAGGERTY, Chief Judge:

Magistrate Judge Jelderks issued a Findings and Recommendation in this action (Doc. #100) in which the Magistrate Judge recommended that defendants' Motion to Dismiss and for Summary Judgment (Doc. #14) should be granted, and plaintiffs' Cross Motion for Summary Judgment on the fifth claim (Doc. #53) should be denied. Plaintiffs filed objections to the Findings and Recommendation. The matter was then referred to this court.

After the referral, however, and after plaintiffs sought leave to supplement the record, counsel for the defendants notified this court of an Order issued by the United States Court of Appeals for the Ninth Circuit in mid-January 2004. The order advised the parties to report to the Ninth Circuit if no action was taken in the case by this court within thirty days. In light of these instructions and the fact that thirty days had nearly expired upon receipt of defendants' notice, this court elected to await the parties' notice to the Ninth Circuit before proceeding further with review of the Findings and Recommendation and the objections to it.

In absence of any record of this notification or any further instructions from the Ninth Circuit, this court now undertakes the task of considering the objections. When a party objects to any portion of the Magistrate's Findings and Recommendation, the district court must make a *de novo* determination of that portion of the Magistrate's report. Fed. R. Civ. P. 72(b); *see also McKeever v. Block*, 932 F.2d 795, 798 (9th Cir. 1991). The district court must exercise its discretion rather than summarily accepting or denying the Magistrate Judge's findings. *United States v. Howell*, 231 F.3d 615, 622 (9th Cir. 2000).

The objections were filed in a timely manner. The court has given the file of this case a *de novo* review, and has also

carefully evaluated the Magistrate's Findings and Recommendations, the objections, and the entire Record. The court has also considered the supplemental briefing for which leave to file was sought and granted. After this consideration, this court concludes that the Findings and Recommendation is sound, correct, and entitled to adoption.

The Findings and Recommendation provides a thorough analysis of the facts and circumstances regarding this litigation, and the analysis need not be repeated. Plaintiffs do not object to granting summary judgment to defendants on plaintiffs' Fifth Claim, but object to the Magistrate Judge's recommendation that the First through Fourth Claims should be dismissed.

Magistrate Judge Jelderks recommended dismissal of the first four claims on grounds that plaintiffs lacked a private right of action to enforce provisions of the Medicaid Act under 42 U.S.C. § 1983. The Findings and Recommendation concluded that the Medicaid provisions relied upon by plaintiffs fail to unambiguously confer individual rights upon plaintiffs. Plaintiffs' objections are addressed in the order presented to the court.

Plaintiffs' first objection asserts that the Findings and Recommendation "glosses over" the fact that Plaintiffs seek nursing facility services, and the HCBS (the Oregon Home and Community Bases Services) waiver services – which the Findings and Recommendation instead focuses upon – are an alternative delivery system for those mandatory nursing facility services. Pls. Objs. at 3. As acknowledged by plaintiffs, the Findings and Recommendation contains multiple references to the fact that defendants' actions in dispute have terminated nursing facility services as well as HCBS waiver services. However, plaintiffs refer to a passage from the Findings and Recommendation as the "primary offending paragraph"

because the passage addresses whether Congress unambiguously conferred personal rights under the HCBS waiver program. Pls. Objs. at 3-4, quoting Findings and Recommendation at 16-17.

This objection is without merit. The working of the specific passage identified by plaintiffs falls short of establishing that the Magistrate Judge erred in his comprehension of plaintiffs' claims, his consideration of all applicable statutes, or his conclusions.

Second, plaintiffs object that the Findings and Recommendation failed to apply the three-part test set fourth in *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997) for determining the enforceability of a federal law under 42 U.S.C. § 1983. Plaintiffs complain that "after acknowledging the validity of the *Blessing* test, the Recommendation never applies it or even mentions it again." Pls. Objs. at 5. However, the Findings and Recommendation correctly recognized that the Supreme court clarified but did not disavow *Blessing* in its decision in *Gonzaga Univ. v. Doe*, 536 U.S. 273, 280-83 (2002); *see also Save Our Valley v. Sound Transit*, 335 F.3d 932, 943 n. 10 (9th Cir. 2003). The Supreme Court in *Gonzaga* rejected assertions that *Blessing* "permit[s] anything short of an unambiguously conferred right to support a cause of action brought under § 1983." *Gonzaga*, 536 U.S. at 282. The Findings and Recommendation's subsequent analysis reflected that the reasoning in *Blessing* has been clarified by *Gonzaga*. This recognition of the applicable case authorities is proper, and plaintiffs' objections to the contrary are overruled.

Third, plaintiffs object to the conclusion that the Medicaid Act provisions relied on by plaintiffs do not confer enforceable rights as construed under *Blessings* and *Gonzaga*. This issue deservedly has been the subject of extensive briefing before the Magistrate Judge and as part of the objections and

supplemental filings submitted after the Findings and Recommendation was issued. Courts nationally have examined similar questions, and the Findings and Recommendation relied on several decisions in arriving upon its conclusions. While the Third Circuit has subsequently reversed in part one of the decisions cited in the Findings and Recommendation in doing so the court stated "the District Court correctly recognized that Sections 1396 and 1396c do not contain the 'sort of explicit, rights-creating language found in Title VI....'" *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 192 (3rd Cir. 2004) (quoting *Sabree v. Houston*, 245 F. Supp.2d 653, 659 (E.D. Pa. 2003)). The Third Circuit proceeded to conclude that the language used by Congress in 42 U.S.C. §§ 1396a(a)(10), 1396d(a)(15), and 1396a(a)(8) does, however, explicitly create rights. *Id.* In so doing, the court acknowledged that "plumbing for congressional intent by balancing the specific language of a few discrete provision of the Title XIX against the larger structural elements of the statute is a difficult task." *Id.*

This court agrees. Nevertheless, the Findings and Recommendation remains in large measure consistent with the authorities cited therein, including *M.A.C. v. Betit*, 284 F.Supp.2d 1298 (D. Utah 2003), which recognized that under *Gonzaga*, disabled individuals eligible for HCBS services who are wait-listed for such services lack a private right of action to enforce §§ 1396, 1396a(a)(23), 1396(a)(8 and 1396a(a)(10). *Id.* at 1306. While there are also some other authorities to which plaintiffs carefully and thoroughly cite that support departing from the Findings and Recommendation's conclusions, this court adopts the Findings and Recommendation as well-reasoned and correct. The provisions of the Medicaid Act as issue in this action do not contain rights-creating language unequivocally conferring an individual right to support a cause of action under § 1983.

Next, plaintiffs object to the Findings and Recommendation's reference to the existence of administrative review procedures as one factor that was considered in attempting to glean Congressional intent regarding the possible creation of individually enforceable private rights. *See* Findings and Recommendation at 23, citing *Gonzaga*, 536 U.S. at 290. This court concludes that the Findings and Recommendation correctly balances this factor in reaching its conclusions.

Plaintiffs next take exception to the conclusion in the Findings and Recommendation that "Section 1396d(f) simply provides definitions, and cannot be characterized as giving rise to substantive rights to the services described." Findings and Recommendation at 23. The Magistrate Judge did not err in reaching this conclusion. *See 31 Foster Children v. Bush*, 329 F3d 1255, 1271 (11th Cir. 2003) (because passages of the Adoption Assistance and Child Welfare Act at issue are definitional in nature, "they alone cannot and do not supply a basis for conferring rights enforceable under § 1983;"), citing *Gonzaga*, 536 U.S. at 280; *see also Charlie H. v. Whitman*, 83 F.Supp.2d 476, 190 (D.N.J. 2000).

Plaintiffs' next objection pertains to their Fourth Claim, which alleged that termination of plaintiffs' services violated 42 U.S.C. § 1396a(a)(10)(B). Plaintiffs argue that the Findings and Recommendation improperly rejected that claim because defendants allegedly "withdrew their one challenge to that claim." Pls. Obj. at 19. Defendants acknowledge that they withdrew one of the challenges they raised against the Fourth Claim, and instead focused their argument in their Reply brief on the assertion that the provision at issue does not create enforceable rights under § 1983. This assertion was presented by defendants in their opening Memorandum when they explicitly identified the Fourth Claim as one of plaintiffs' termination claims under a caption stating "Plaintiffs' termination of benefits claim fails to state a claim for relief," and then as-

serted in the following caption that "There is no private right of action under § 1983." *See* Memorandum in Support of the Motion to Dismiss at 10.

Plaintiffs' next objection is that the Magistrate Judge improperly considered matters outside of the pleadings. Plaintiffs cite to the reference in the Findings and Recommendation pertaining to information obtained from submissions to and statements issued by the federal Centers for Medicare and Medicaid Services (CMS). Defendants submitted letters from the CMS as attachments to the Supplemental and Second Supplemental Affidavits of Deanna Hartwig. There were no objections to these supplemental submissions from plaintiffs, and no requests for discovery or to convert the pending motion into a motion for summary judgment. Moreover, although portrayed by plaintiffs as "factual findings," the objectionable passages pertain to actions taken by CMS (approval of amendments), the purposes of the amendments, notice that the amendments would be approved, the date portions of the amendments were granted, and consequences of these actions. *See* Findings and Recommendation at 7-8. Plaintiffs contend that these "findings" are inappropriate and overly emphasize HCBS waiver services.

This court disagrees. To the extent that these references in the Findings and Recommendation possibly fall outside the parameters of the Motion to Dismiss, they are construed as matters of public record, of which judicial notice may be taken. *See* Fed. R. Evid. 201. This objection is overruled.

Plaintiffs' final objection is that they should be permitted leave to amend their Complaint rather than have their claims dismissed with prejudice. The court notes that plaintiffs filed a First Amended Complaint on March 24, 2003, (*see* Doc. #13), but never again formally moved for leave to further amend from either the Magistrate Judge or this court. In de-

ciding whether to grant leave to amend, courts are guided by five factors: (1) bad faith; (2) undue delay; (3) prejudice to the opposing party; (4) futility of the amendment; and (5) whether the party previously amended its pleadings. *Bonin v. Calderon*, 59 F.3d 815, 845 (9th Cir. 1995). Futility by itself is sufficient to justify the denial of a motion for leave to amend. *Id.* A court's discretion regarding whether to grant leave is especially broad after the court has already previously granted leave to amend. *Griggs v. Pace Am. Group, Inc.*, 170 F.3d 877, 879 (9th Cir. 1999).

This court notes that plaintiffs have already amended their Complain before, and that the opposing parties could suffer significant prejudice from plaintiff's amendment at this state in the litigation, after the extensive briefing and arguments that have been presented here as well as in plaintiffs' previously adjudicated Motion for Preliminary Injunction. In light of this, and the apparent futility of amendment under the binding authorities as presently interpreted, plaintiffs. Request for leave to amend is denied.

CONCLUSION

For the reasons provided, the Findings and Recommendation (Doc. #100) is adopted as follows: defendants' Motion to Dismiss or for Summary Judgment (Doc. #14) is granted insofar as summary judgment is granted against plaintiffs' Fifth Claim, and plaintiffs' remaining claims are dismissed with prejudice. Plaintiffs' Motion for Summary Judgment (Doc. #53) is denied.

IT IS SO ORDERED

DATED this 24 day of June, 2004.

/s/ Ancer L. Haggerty
Ancer L. Haggerty
United States District Judge

FOR PUBLICATION
UNITED STATES COURT OF APPEALS
THE NINTH CIRCUIT

WILLIAM W. WATSON, JR.; CHARLES E. PAPST, JR., by and through his next friend Nida Morris; ROBERT WOODFORD, by and through his next friend, Anita Geistlinger; HEIDI HALTER, by and through her next friend Hayley Adams; AMAR JUSLEN, by and through his next friend, Raul Juslen; IRMA RADTKE, by and through her next friend, Hans Radtke; SHELLIE A. CAMERSON; and OREGON ADVOCACY CENTER,

Plaintiffs-Appellants,

vs.

GARY WEEKS, in his official capacity as Director, Oregon Department of Human Services; LYNN READ, in her official capacity as Acting Administrator of the Office of Medical Assistance Programs; and JAMES TOEWS, in his official capacity as Acting Administrator, Seniors and People with Disabilities,

Defendants-Appellees.

No. 04-35704
D.C. No.
CV-03-00227-HA
OPINION

Appeal from the United States District Court

for the District of Oregon
Ancer Haggerty, District Judge, Presiding

Argued and Submitted
December 13, 2005—Portland, Oregon

Filed February 8, 2006

Before: Procter Hug, Jr., Susan P. Graber, and Richard R. Clifton, Circuit Judges.

Opinion by Judge Hug

COUNSEL

Lauren K. Saunders, National Senior Citizens Law Center, Washington, D.C., for the appellants.

Janet A. Metcalf, Assistant Attorney General, Salem, Oregon, for the appellees.

Bruce Vinery, AARP Foundation Litigation, Washington, D.C., and Jane Perkins, National Health Law Program, Chapel Hill, North Carolina, for *amici curiae*.

OPINION

HUG, Circuit Judge:

Seven Medicaid-eligible Oregon residents and the Oregon Advocacy Center (collectively the "Plaintiffs") appeal the district court's order dismissing their action against Oregon state health officials, seeking declaratory and injunctive relief. Their appeal presents an issue of first impression for this circuit: whether certain provisions of the Medicaid Act, 42 U.S.C. §§ 1396a(a)(10) and 1396a(a)(17), create individual rights enforceable under 42 U.S.C. § 1983 ("section 1983").

The seven individual plaintiffs, who are seniors and disabled individuals, had received home and community-based services as an alternative to Medicaid institutional nursing facility services. They lost their Medicaid eligibility, however,

when the Oregon Department of Human Services (the "Department") scaled back the state's Medicaid program in the face of a budget crisis. Plaintiffs sued officials in the Department under section 1983 in federal district court. The individual plaintiffs alleged that they required the level of care that entitles them to nursing facility services under the Medicaid Act. They further alleged that the Department's actions violated both section 1396a(a)(10), which requires states to provide nursing facility services to eligible individuals, and section 1396a(a)(17), which requires states to use reasonable standards in setting Medicaid eligibility.

The district court granted the Department's motion to dismiss the complaint under Federal Rule of Civil Procedure ("FRCP") 12(b)(6), concluding that the Medicaid Act provisions in question do not create individual rights enforceable through section 1983. In dismissing the case, the court also denied Plaintiffs leave to amend their complaint.

Plaintiffs appeal the dismissal of their complaint and the denial of leave to amend. We have jurisdiction under 28 U.S.C. § 1291, and we hold that section 1396a(a)(10) creates an individual right enforceable under section 1983. We also hold that section 1396a(a)(17) does not create such an individual right. We do not reach the question of the district court's denial of leave to amend. The district court is thus affirmed in part, and reversed in part. We remand for further proceedings consistent with this opinion.

I

BACKGROUND

A. *The Medicaid Framework*

Medicaid is a cooperative Federal-State program with the "purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance

on behalf of . . . individuals, whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396. States choosing to participate in the program, such as Oregon, must develop a medical assistance plan meeting the approval of the federal Secretary of Health and Human Services (the "Secretary"). *See id.* A participating state receives federal reimbursement for "medical assistance" that it renders under its approved plan. *See id.*

The "medical assistance" provided by a state plan must include certain minimum services to "all individuals" who are financially eligible. *See* 42 U.S.C. § 1396a(a)(10)(A) (identifying the seven subsections of 42 U.S.C. § 1396d(a) that describe the minimum services). Among the services that must be provided are "nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older." 42 U.S.C. § 1396d(a)(4)(A). The Medicaid Act defines a "nursing facility" as an institution primarily engaged in providing skilled nursing care, rehabilitation services, or regular health-related care and services (above the level of room and board) available only in institutions. *See* 42 U.S.C. § 1396d(c) (referring to 42 U.S.C. § 1396r(a) for definition); 42 U.S.C. § 1396r(a)(1).

A state plan must also provide "reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan," 42 U.S.C. § 1396a(a)(17), and must include necessary safeguards to assure that eligibility for services is provided "in a manner consistent with simplicity of administration and the best interests of the recipients." 42 U.S.C. § 1396a(a)(19).

A related provision of Medicaid is the Home and Community Based Services ("community-based services") waiver program. A community-based services waiver permits a state plan to include as "medical assistance" certain home and

community-based services rendered to individuals who otherwise would require nursing facility care that could be reimbursable under the state plan. *See* 42 U.S.C. § 1396n(c)(1). A waiver program must include a method for assessing whether possible service recipients need inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally ill. 42 U.S.C. § 1396n(c)(2)(B). The implementing regulations for § 1396n(c)(1) provide that a state may terminate its waiver at any time upon notice to the recipients and Secretary. *See* 42 C.F.R. § 441.307. A waiver may also be modified at any time, subject to the Secretary's approval. *See* 42 C.F.R. § 441.355.

B. *Oregon's Community-Based Services Waiver*

Oregon initiated its community-based services waiver program in 1981. The waiver included the Client Assessment and Planning System, whereby the state classified eligible individuals into service priority levels based on medical need; the levels number from one to eighteen, with level one reflecting the most urgent medical need.[1] Oregon uses a single set of criteria for determining eligibility, whether services are in nursing facilities or community based.[2] The original waiver provided care to all individuals assessed at levels one through seventeen. The Department also made community-based services available to any person eligible for institutional nursing care, leading to a large reduction in the services that had to be provided at nursing facilities.

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[1] The service priority levels are codified in Oregon's administrative rules. Or Admin. R. 411-015-0010 (2005).

[2] *See* Or. Admin. R. 411-015-01100 (2005) (establishing eligibility for nursing facility and community-based on the service priority levels of Or. Admin. R. 411-015-0010.

More recently, however, Oregon has eliminated coverage for some service levels, purely to cut state spending. On January 27, 2003, due to budget difficulties, the Department submitted a proposed waiver modification to eliminate eligibility for individuals in service levels fifteen to seventeen. The Secretary approved the modification. On February 24, 2003, the Department successfully requested another modification: the elimination of eligibility for individuals in levels ten to fourteen. The Oregon legislature subsequently restored funding through August 31, 2003, for service levels ten and eleven, and restored levels ten through thirteen for the 2003-2005 budget. Current Oregon regulations reflect these limitations, providing that only those individuals in levels one through thirteen are eligible for services.[3]

Under Oregon's cutbacks, individuals who are deemed ineligible for nursing facility or community-based services cannot challenge the state's decision to eliminate eligibility of a service level, but may challenge only their placement into their particular service level. Oregon estimated that elimination of levels fifteen through seventeen affected 4,000 individuals in community-based settings and 85 individuals in nursing facilities. The elimination of levels ten through fourteen was projected to terminate services for 6,100 individuals in community-based settings and 300 individuals in nursing facilities.

II

COURT PROCEEDINGS

On February 20, 2003, Plaintiffs filed a complaint against the Department in federal district court for the District of

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[3] Or Admin. R. 411-015-0015(1) (2005) (rule is entitled "Current Limitations").

Oregon.[4] On March 24, 2003, before the Department had responded, Plaintiffs filed a First Amended Complaint. The amended complaint set forth five claims for relief; Plaintiffs are appealing only the district court's dismissal of the first three of these claims. The first claim alleged that the Department's withdrawal of eligibility violated, *inter alia*, 42 U.S.C. § 1396a(a)(10), which requires that state Medicaid plans provide nursing facility services to eligible individuals. The second claim alleged that the Department's actions violated, *inter alia*, 42 U.S.C. § 1396a(a)(17)'s "reasonable standards" requirement. The third claim alleged that the Department violated 42 U.S.C. § 1396a(a)(17) by assessing Plaintiffs' medical need for nursing facility services using agents who lacked the necessary professional qualifications and training and who employed subjective and inaccurate judgments.

On April 22, 2003, the Department moved to dismiss the claims under FRCP 12(b)(6). On November 24, 2003, the magistrate judge filed a report that recommended granting the motion. On December 10, 2003, Plaintiffs filed objections to the magistrate judge's findings and recommendations. They stated that they were "entitled to an opportunity to amend the complaint," identifying two ways in which their amended

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[4] Plaintiffs requested, among other remedies, a preliminary injunction enjoining the Department from terminating services to persons assessed at service levels ten through seventeen. On June 16, 2003, the district court denied the Plaintiffs' preliminary injunction request. Plaintiffs interlocutorily appealed, and the Ninth Circuit granted the Department's motion to dismiss the appeal as moot, because the district court had in the meantime entered an order dismissing the action. *Watson v. Thorne*, 107 Fed. Appx. 150 (9th Cir. 2004) (unpublished order).

complaint might be amended further. First, to avoid any misperception that Plaintiffs were alleging a right to community-based services, rather than nursing facility services, Plaintiffs stated that they could "emphasize more strongly that they assert a statutory right" to nursing facility services. Second, Plaintiffs stated they could add causes of action under the Supremacy Clause.

On June 25, 2004, the district court entered a judgment and order that granted the Department's 12(b)(6) motion. The district court adopted the findings and recommendations of the magistrate judge. In the order, the district court also denied Plaintiffs leave to amend their complaint. The court noted that Plaintiffs already had amended their complaint "and that the opposing parties could suffer significant prejudice from plaintiffs' amendment at this stage in the litigation, after the extensive briefing and arguments that have been presented." In addition, the court noted "the apparent futility of amendment under the binding authorities as presently interpreted." The district court entered final judgment against Plaintiffs on June 25, 2004. Plaintiffs timely filed a Notice of Appeal on July 21, 2004.

III

STANDARD OF REVIEW

We review *de novo* the district court's decision to grant a motion to dismiss pursuant to FRCP 12(b)(6). *ASW v. Oregon*, 424 F.3d 970, 974 (9th Cir. 2005). We accept as true all well-pleaded facts in the complaint and construe them in the light most favorable to the nonmoving party. *Id.* A claim should be dismissed only if it appears beyond doubt that the plaintiff can establish no set of facts under which relief could be granted. *Pacheco v. United States*, 220 F.3d 1126, 1129 (9th Cir. 2000).

IV

STATUTORY ANALYSIS

It may be helpful to provide a brief explanation of the applicable law for determining whether a particular federal statute can be enforced through a private right of action under section 1983. Under section 1983, persons are liable if they act under color of law to deprive individuals of "any rights, privileges, or immunities secured by the Constitution and laws" of the United States. 42 U.S.C. § 1983. In *Wilder v. Virginia Hospital Ass'n*, the Supreme Court allowed a section 1983 action by health care providers to enforce a reimbursement provision of the Medicaid Act requiring "reasonable and adequate" payment, holding that the provision explicitly conferred specific monetary entitlements upon the plaintiffs. 496 U.S. 498, 501-02, 110 S. Ct. 2510, 110 L. Ed. 2d 455 (1990), *superseded on other grounds by statute as discussed in Alaska Dep't of Health & Soc. Servs. v. Ctrs. for Medicare & Medicaid Servs.*, 424 F.3d 931 (9th Cir. 2005).[5] The *Wilder* Court explained that the provision required the state plan to provide for reimbursement to facilities and that the intent to benefit such facilities was unmistakable. *Id.* at 510.

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[5] The provision at issue in *Wilder* read:

> a State plan for medical assistance must –
>
> provide . . . for payment . . . of the hospital services . . . provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . . .

Wilder, 496 U.S. at 502-03 (quoting 42 U.S.C. § 1396a(a)(13)(A) (1982 & Supp. V)).

In *Suter v. Artist M.*, the Court distinguished *Wilder* and found no section 1983 right for parents and children who sued under the Adoption Assistance and Child Welfare Act of 1980, because "reasonable efforts" to keep children out of foster homes imposed only "a rather generalized duty" on the state and conferred no individualized rights.[6] 503 U.S. 347, 363, 112 S. Ct. 1360, 118 L. Ed. 2d 1 (1992). The *Suter* Court explained that *Wilder's* term "reasonable and adequate" was accompanied by sufficiently detailed guidance to a court that it could be judicially enforced. *Suter*, 503 U.S. at 359. By contrast, the statutory term in *Suter*, "reasonable efforts," provided no such guidance and thus a court could not readily ascertain the outlines of the alleged right. *Id.* at 359-60. *Suter* has been since limited as a bar to finding a section 1983 right; Congress responded to the opinion by enacting the "*Suter*

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[6] The relevant provision was:

> (a) Requisite features of State plan
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> In order for a State to be eligible for payments . . ., it shall have a plan approved by the Secretary which –
>
> . . . . .
>
> (3) provides that the plan shall be in effect in all political subdivisions of the State . . . ;
>
> . . . . .
>
> (15) . . . provides that . . . reasonable efforts will be made . . . to prevent the need for removal of the child from his home
>
> . . . .

Suter, 503 U.S. at 351 (quoting 42 U.S.C. §§ 671(a)(3), (15)(A) (1988 & Supp. I)).

fix," 42 U.S.C. § 1320a-2, which blocks any Medicaid Act provision from being deemed unenforceable by an individual merely because the provision contains state plan requirements.[7]

[1] In 1997, the Supreme Court established the current three-prong test for determining whether a particular federal statute can be enforced through a private right of action under section 1983. *Blessing v. Freestone*, 520 U.S. 329, 340, 117 S. Ct. 1353, 137 L. Ed. 2d 569 (1997). The *Blessing* test requires: 1) that Congress intended the statutory provision to benefit the plaintiff; 2) that the asserted right is not so "vague and amorphous" that its enforcement would strain judicial competence; and 3) that the provision couch the asserted right in mandatory rather than precatory terms. *Id.* at 340-41. If the provision meets this test, then there is a presumption that it is subject to private enforcement under section 1983. *Id.* at 341. The presumption is rebutted, however, if Congress expressly or impliedly foreclosed enforcement under section 1983; an implied foreclosure occurs if Congress created "a comprehensive enforcement scheme that is incompatible with individual enforcement." *Id.*

The Supreme Court clarified the first prong of the *Blessing* test in *Gonzaga University v. Doe*, 536 U.S. 273, 122 S. Ct. 2268, 153 L. Ed. 2d 309 (2002). In *Gonzaga*, the Court

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[7] The statute reads in part:

> In an action brought to enforce a provision of this chapter, such provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan.

42 U.S.C. § 1320a-2.

held that congressional intent to benefit the plaintiff must be shown by statutory language "phrased in terms of the persons to be benefited." *Id.* at 284 (quoting *Cannon v. Univ. of Chicago*, 441 U.S. 677, 692 n.13, 99 S. Ct. 1946, 60 L. Ed. 2d 560 (1979)). "Anything short of an unambiguously conferred right" will not support a 1983 action. *Gonzaga*, 536 U.S. at 283. The Court explained that section 1983 was intended to enforce "rights" as opposed to "benefits" or "interests," the latter two being too broad or vague for judicial enforcement. *Id.* To create enforceable rights, the statutory provision in question must focus on individual rights to benefits, rather than only the aggregate or systemwide policies and practices of a regulated entity. *See id.* at 287-88. As exemplars of statutory provisions that create section 1983 rights, the Court discussed Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972, both of which use the wording "no person . . . shall . . . be subjected to discrimination." *Id.* at 284 & n.3.

V

EXISTENCE OF A PRIVATE RIGHT OF ACTION

As a threshold matter, we accept as true Plaintiffs' statement that those individuals assessed at levels one through seventeen need nursing facility services. *See ASW*, 424 F.3d at 974. Plaintiffs' medical need may indeed be more than a well-pleaded fact; the magistrate judge found that "plaintiffs are individuals whose serious medical problems and cognitive limitations require that they either be cared for in a nursing facility or receive an equivalent level of care in community settings."

A. *Section 1396a(a)(10) Creates a Private Right of Action*

[2] According to section 1396a(a)(10), a state plan for medical assistance must provide "for making medical assistance available, including at least the care and services listed

in paragraphs (1) through (5) . . . of section 1396d(a) of this title," to "all individuals" meeting specified financial eligibility standards. 42 U.S.C. § 1396a(a)(10).

In holding that this statutory provision creates a right enforceable by section 1983, we join five federal circuit courts that have already so held.[8] No circuit court has held that section 1396a(a)(10) does not create a section 1983 right.

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[8] Post-Gonzaga, the Third and Fifth Circuits have found an enforceable section 1983 right in section 1396a(a)(10). *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180 (3d Cir. 2004); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581 (5th Cir. 2004). Pre-*Gonzaga*, three other federal circuits had held that a section 1983 right exists in section 1396a(a)(10). *Westside Mothers v. Haveman*, 289 F.3d 852 (6th Cir. 2002); *Pediatric SpecialtyCare, Inc. v. Ark. Dep't of Human Servs.*, 293 F.3d 472 (8th Cir. 2002); *Miller v. Whitburn*, 10 F.3d 1315 (7th Cir. 1993).

Other federal circuits have found section 1983 rights in other statutes that have wording akin to that in section 1396a(a)(10). In 2004, post-*Gonzaga*, the Second Circuit held that 42 U.S.C. § 1396r-6, providing for transitional Medicaid assistance, creates an individual section 1983 right. *Rabin v. Wilson-Coker*, 362 F.3d 190, 201-02 (2d Cir. 2004) (statute requires that "each State plan approved under this subchapter must provide that each family which was receiving aid . . . shall . . . remain eligible for assistance under the plan").

The First Circuit also held post-*Gonzaga* that another similar Medicaid Act provision, section 1396a(a)(8), created an enforceable right under section 1983. *Bryson v. Shumway*, 308 F.3d 79, 88 (1st Cir. 2002) (statute requires that "medical assistance . . . shall be furnished with reasonable promptness to all eligible individuals").

[3] Our initial inquiry under the first prong of *Blessing* is whether section 1396a(a)(10) reveals a congressional intent to create an individualized right. We hold that it does. Significantly, the provision is phrased in terms of the individuals benefited. *See Gonzaga*, 536 U.S. at 283-84 (stating that a statute must be so phrased to create a section 1983 right). *Gonzaga* cited text from Titles VI and IX, "no person . . . shall . . . be subjected to discrimination," as language conferring a section 1983 right. *Id.* at 284 & n.3. In the instant appeal, the relevant phrase is "[a] State plan . . . must provide for making medical assistance available . . . to all individuals." (Emphasis added). This language is unmistakably focused on the specific individuals benefited; it provides for medical assistance to all individuals who meet eligibility requirements. The wording of section 1396a(a)(10) is similar to the statutory provision we examined in *Price v. City of Stockton* – "Each grantee shall provide for reasonable benefits to any person"[9] — which we held "requires that benefits be provided to particular persons . . . [and] evinces a clear intent to create a federal right." 390 F.3d 1105, 1111 (9th Cir. 2004) (per curiam).[10]

Following its earlier holding in *Westside Mothers*, the Sixth Circuit, post-*Gonzaga*, has found a section 1983 right in section 1396a(a)(3) (Medicaid Act provision requiring a "fair hearing before the State agency" for individuals whose "claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness"). *Gean v. Hattaway*, 330 F.3d 758, 772-73 (6th Cir. 2003).

[9] 42 U.S.C. § 5304(k).

[10] In *Price*, we interpreted a provision of the Housing and Community Development Act requiring assistance to residents displaced by federally-funded redevelopment activities:

There is strong support for this reading of section 1396a(a)(10) in holdings by the Third and Fifth Circuits, and we endorse these courts' reasoning. In *Sabree ex rel. Sabree v. Richman*, the Third Circuit noted that "it [is] difficult, if not impossible, as a linguistic matter, to distinguish the import of the relevant [Medicaid Act] language — 'A State plan must provide' — from the 'No person shall' language of Titles VI and IX." 367 F.3d 180, 190 (3d Cir. 2004). The court observed that the "individual focus" of section 1396a(a)(10) is "unmistakable." *Id.* The Third Circuit convincingly noted that the focus of section 1396a(a)(10) is on the individual protected, rather than on the entity. *Id.*

In *S.D. ex rel. Dickson v. Hood*, the Fifth Circuit similarly held that section 1396a(a)(10) features "precisely the sort of 'rights-creating' language identified in *Gonzaga* as critical to demonstrating a congressional intent to establish a new right." 391 F.3d 581, 603 (5th Cir. 2004).[11] According to the Fifth Circuit, the only "potentially material difference" between section 1396a(a)(10) and the *Gonzaga*-approved rights-creating language of Titles VI and IX is that section 1396a(a)(10) requires state action under a medical assistance plan. *Id.* However, the Fifth Circuit cited section 1320a-2, the "*Suter* fix," to establish that this provision in section

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> Each grantee shall provide for reasonable benefits to any person involuntarily and permanently displaced as a result of the use of assistance received under this chapter to acquire or substantially rehabilitate property.

42 U.S.C. § 5304(k); *see* 390 F.3d at 1112.

[11] In *ASW v. Oregon*, we approvingly cited this sentence of *S.D.* in our discussion of the first prong of *Blessing*. 424 F.3d 970, 976 (9th Cir. 2005).

1396a(a)(10) is not unenforceable merely because it requires action under a state plan. *Id.*

Within this circuit, we recently implied that section 1396a(a)(10) may create a section 1983 right. In *Sanchez v. Johnson*, we undertook a *Blessing* analysis and held that another Medicaid Act provision, section 1396a(a)(30)(A), failed the first prong. 416 F.3d 1051, 1062 (9th Cir. 2005). In so doing, we cited *Sabree* and contrasted section 1396a(a)(30)(A) with section 1396a(a)(10):

> Although 42 U.S.C. § 1396a(a) sets out a comprehensive list of requirements that a state plan must meet, it does not describe every requirement in the same language. Some requirements, such as those addressed in *Sabree* [§ 10], focus on individual recipients, while others are concerned with the procedural administration of the Medicaid Act by the States and only refer to recipients, if at all, in the aggregate. Section 30(A) is one of the latter provisions . . . .

Sanchez, 416 F.3d at 1062.

For contrast, it may be helpful to discuss a Medicaid Act provision that we have held did not create a section 1983 right. In *San Lazaro Ass'n v. Connell*, 286 F.3d 1088, 1099 (9th Cir. 2002), we held that 42 U.S.C. § 1396a(a)(5)'s requirement that a state "provide for the establishment . . . of a single State agency to administer . . . the [State's] plan," although for the benefit of medical providers, did not give providers a section 1983 right because it is "a structural programmatic requirement that facilitates federal oversight of

state Medicaid programs."[12] Indeed, section 1396a(a)(5) fails to mention providers at all. It is clearly directed at the aggregate practices of a regulated entity, the state. The wording of section 1396a(a)(10) is sharply different: Congress used "all individuals" as a focal term and established entitlements to specific benefits for individuals.

[4] In addition to meeting the first prong under *Blessing*, section 1396a(a)(10) meets the second and third prongs. It sets forth explicitly what nursing facility services must be offered, through reference to particular provisions of section 1396d(a). These provisions supply concrete and objective standards for enforcement; they are hardly vague and amorphous. *See Suter*, 503 U.S. at 370 (Blackmun, J., dissenting) (explaining that to be judicially enforceable, a right must be expressed at least in terms of objective standards). Section 1396a(a)(10) is also expressly worded in mandatory, not precatory terms; it obviously sets out specific requirements for state plans. *See Wilder*, 496 U.S. at 512 (finding that a Medicaid Act provision that a state plan "must" provide payments to hospitals couches an asserted right in mandatory, not precatory, terms).

[5] Because section 1396a(a)(10) requires states to provide particularly specified benefits to particularly specified types of individuals, there is a presumption of a section 1983 right under *Blessing*. *See* 520 U.S. at

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[12] Section 1396a(a)(5) mandates that a participating state "provide for the establishment or designation of a single State agency to administer or to supervise the administration of the [State's] plan."

341. The Department must rebut this presumption by demonstrating that Congress foreclosed the right. *See id.* The Supreme Court has stated that a court should "not lightly conclude that Congress intended to preclude reliance on § 1983 as a remedy" for deprivation of a federally secured right. *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103, 107, 110 S. Ct. 444, 107 L. Ed. 2d 420 (1989) (citations and internal quotations omitted). The Medicaid Act does not expressly foreclose a section 1983 right, so the Department must show that Congress provided a comprehensive remedial scheme that is incompatible with individual actions under the *Blessing* analysis.

[6] The Department cannot rebut the presumption of a section 1983 right.[13] Although there are state administrative procedures available to Plaintiffs under section 1396a(a)(3), "[t]he availability of state administrative procedures ordinarily does not foreclose resort to § 1983." *Wilder*, 496 U.S. at 523. In *Wilder*, medical providers had the right to contest individual claims for payment before a state agency, but could not challenge the overall method by which payment rates were calculated. *Id.* The Court found that such "limited" administrative procedures could not be considered comprehensive and could not show congressional intent to foreclose a section 1983 right. *Id.* In the instant appeal, the administrative rights granted by the Department are similar to those in *Wilder*; individuals may only appeal their service level determination, not the state's underlying decision to not serve

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[13] The Department's brief did not make any attempt to rebut the presumption.

individuals in certain levels. The limited rights available to Plaintiffs are also similar to those analyzed by this court in *ASW v. Oregon*, where we found that providing adoption assistance beneficiaries with a fair hearing before a state agency regarding individual benefit claims was not a comprehensive enforcement mechanism incompatible with a section 1983 action. 424 F.3d at 978. Plaintiffs have established a section 1983 right under section 1396a(a)(10).

B. *Section 1396a(a)(17) Does Not Create a Private Right of Action*

[7] We are the first federal circuit to address whether section 1396a(a)(17) creates a section 1983 right.[14] Section 1396a(a)(17) provides that a state plan for medical assistance "must . . . include reasonable standards (which shall be comparable for all groups . . .) for determining eligibility for and the extent of medical assistance under this plan."

[8] There is insufficient evidence of congressional intent to create a section 1983 right under this provision. Section 1396a(a)(17) is a general discretion-

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[14] One published federal district court case has held that there is no private right implied under section 1396a(a)(17). *Sanders ex rel. Rayl v. Kan. Dep't of Soc. & Rehab. Servs.*, 317 F. Supp. 2d 1233, 1250 (D. Kan. 2004).

Three published federal district court cases have held that there is a private right implied under section 1396a(a)(17), and we have considered these cases but found them unpersuasive. *See* Mendez v. Brown, 311 F. Supp. 2d 134, 139 (D. Mass. 2004); *Markva v. Haveman*, 168 F. Supp. 2d 695, 711 (E.D. Mich. 2001); *Smith v. Palmer*, 24 F. Supp. 2d 955, 963-64 (N.D. Iowa 1998).

granting requirement that a state adopt reasonable standards. It fails to provide an "unambiguously conferred right" and fails the first prong of *Blessing*. The key wording of section 1396a(a)(17) fails to even mention individuals or persons. Unlike section 1396a(a)(10), section 1396a(a)(17) is not framed in terms of the individuals benefited, which is fatal under *Gonzaga* to the existence of a section 1983 right. *See* 536 U.S. at 284. Moreover, the parenthetical statement in section 1396a(a)(17) that the state's reasonable standards "shall be comparable for all groups" puts a focus on the standards themselves and on their aggregate impact, rather than on the benefits to individuals.

[9] Even if section 1396a(a)(17) passed the first *Blessing* prong, it clearly fails the second prong, because the right it would create is too vague and amorphous for judicial enforcement. The provision does not provide meaningful instruction for the interpretation of "reasonable standards" in terms of medical need. It provides guidance only regarding the financial means of a potential beneficiary. *Wilder* found the term rates that "are reasonable and adequate" to be objective and thus judicially manageable because the statute tied it to a benchmark of the "efficiently and economically operated facility." *Wilder*, 496 U.S. at 519-20; *see also Suter*, 503 U.S. at 370-71 (Blackmun, J., dissenting) (explaining that a judicially manageable right need not be mechanical, but must be tied to some objective standard). However, the only guidance of section 1396a(a)(17)(A) regarding medical need eligibility is that state standards be "consistent with the objectives of this subchapter." Judicial enforcement of section 1396a(a)(17) under Plaintiffs' argument would require a court to delve into the medical necessity of particular

types of care. If Congress had intended that result, it would have provided more concrete standards in the statute for determining eligibility based on medical need.

VI

DENYING PLAINTIFFS LEAVE TO AMEND

The parties devoted little briefing and no argument to this portion of the appeal, and we find it unnecessary to reach this question. Once proceedings resume on the remand of Plaintiffs' section 1983 claim under section 1396a(a)(10), Plaintiffs will have an opportunity anew to seek amendment of the pleadings.

VII

CONCLUSION

Plaintiffs have a private right of action under section 1983 to enforce section 1396a(a)(10). They do not have a section 1983 right under section 1396a(a)(17). We AFFIRM the district court in part, and REVERSE in part. The case is REMANDED to the district court for further proceedings consistent with this opinion.

Each party shall bear their own costs on appeal.

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

WILLIAM W. WATSON, et al.,

Plaintiffs-Appellants,

vs.

LYNN READ, in her official capacity as Acting Administrator of the Office of Medical Assistance Program; et al,

Defendants-Appellees.

No. 04-35704

D.C. No. CV-03-00227-ALH
District of Oregon,
Portland

ORDER

Before: HUG, GRABER, and CLIFTON, Circuit Judges

The panel has voted to deny the petition for panel rehearing. Judges Graber and Clifton vote to deny the suggestion for rehearing en banc and Judge Hug so recommends.

The full court has been advised of the suggestion for rehearing en banc and no judge has requested a vote on whether to rehear the matter en banc. Fed. R. App. P. 35.

The petition for panel rehearing and the suggestion for rehearing en banc are DENIED.

42 USCS § 1396a

§ 1396a. State plans for medical assistance

(a) Contents. A State plan for medical assistance must —

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1903 [42 USCS § 1396b] are authorized by this title [42 USCS §§ 1396 et seq.]; and effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for

utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, (C) that each State or local officer, employee, or independent contractor who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer, employee, or contractor, and each partner of such an officer, employee, or contractor shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18, United States Code, and (D) that each State or local officer, employee, or independent contractor who is responsible for selecting, awarding, or otherwise obtaining items and services under the State plan shall be subject to safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) to persons

described in subsection (a)(2) of such section of that Act;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under title I or XVI [42 USCS §§ 301 et seq. or 1381 et seq.], (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under title XVI [42 USCS §§ 1381 et seq.], or by the agency or agencies administering the supplemental security income program established under title XVI [42 USCS §§ 1381 et seq.], or the State plan approved under part A of title IV [42 §§ 601 et seq.] if the State is not eligible to participate in the State plan program established under title XVI [42 USCS §§ 1381 et seq.];

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have

opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1864(a) [42 USCS § 1395aa(a)]), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1861(e)(9) [42 USCS § 1395x(e)(9)] or paragraphs (16) and (17) of section 1861(s) [42 USCS § 1395x(s)(16) and (17)], or, in the case of a laboratory which is in a rural health clinic, of section 1861(aa)(2)(G) [42 USCS § 1395x(aa)(2)(G)];

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1905(a) [42 USCS § 1396d(a)(1)–(5), (17) and (21)], to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., or 1381 et seq. or 601 et seq. or 670 et seq.] (including individuals eligible under this title [42 USCS §§ 1396 et seq.] by reason of section 402(a)(37), 406(h), or 473(b) [42 USCS § 673(b)], or considered by the State to be receiving such aid as authorized under section 482(e)(6)).

(II) with respect to whom supplemental security income benefits are being paid under title XVI [42 USCS § 1381 et seq.] (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193)) [enacted Aug. 22, 1996]) and would continue to be paid but for the enactment of that section or who are qualified severely impaired individuals (as defined in section 1905(q) [42 USCS § 1396d(q)],

(III) who are qualified pregnant women or children as defined in section 1905(n) [42 USCS § 1396d(n)],

(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) for such a family; [,] or

(V) who are qualified family members as defined in section 1905(m)(1) [42 USCS § 1396d(m)(1)],

(VI) who are described in subparagraph (C) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) for such a family, or

(VII) who are described in subparagraph (D) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) for such a family; [and]

(ii) at the option of the State, to any group or groups of individuals described in section 1905(a) [42 USCS § 1396d(a)] (or, in the case of individuals described in section 1905(a)(i) [42 USCS § 1396d(a)(i)], to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause

(i), supplemental security income benefits under title XVI [42 USCS §§ 1381 et seq.], or a State supplementary payment;

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1903(f)(4)(C) [42 USCS § 1396b(f)(4)(C)],

(VI) who would be eligible under the State plan under this title [42 USCS §§ 1396 et seq.] if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1915 [42 USCS § 1396n(c), (d), or (e)] they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1915 [42 USCS § 1396n(c), (d), or (e)],

(VII) who would be eligible under the State plan under this title [42 USCS § 1396 et. seq.] if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1905(o) [42 USCS § 1396d(o)]; [,]